ADMISSIONS PACKET GUIDE CHECKLIST

Welcome to the Northwest Passage Family. We know this packet of forms seems intimidating, but don't worry, it isn't as bad as it looks. Just start with this page as a guide and call us if you have questions - we're here to help! You can reach your admissions specialist directly or contact us at 715-327-4402.

Please check each area upon completion

The forms listed below should be completed and returned to NWP prior to or at the time of admission

- ☐ Admissions Packet Guide Checklist (page 1)
- ☐ Financial Intake Form (page 2)
- ☐ Medical Services Consent Form (page 3)
- ☐ Allergic Reactions & Current Medications (page 4)
- ☐ Physical Exam & Client Medical Health History (page 5)
- ☐ Student Immunization Record - **OUT-OF-STATE CLIENTS ONLY** (page 6)
- ☐ Mandatory Information Releases Checklist (page 7)
- ☐ History of Current and Prior Placements and Services (page 8)
  All significant records related to these interventions must be secured prior to intake or very early in your child/client's placement.
- ☐ Medical - Authorization for Release of Patient-Identifiable Health Information (page 9)
- ☐ School - Authorization for Release of Patient-Identifiable Health Information (page 10)
- ☐ Additional Service Provider(s) - Authorization for Release of Patient-Identifiable Health Information (pages 11-14)
  Please print additional copies of this form if necessary in order to provide complete releases for all previous service providers.
- ☐ Wisconsin Medical Assistance - Authorization for Release Form (page 15)
  Use this form only if your child/client is enrolled in Wisconsin Medical Assistance/BadgerCare, otherwise you may disregard this form.
- ☐ Commercial Insurance - Authorization for Release Form (page 16)
- ☐ Inter-agency - Consent for Disclosure of Confidential Information (page 17)
  This form allows all legal entities within the Northwest system to communicate with one another internally.
- ☐ Local Medical Provider - Consent for Disclosure of Confidential Information (page 18)
- ☐ Local Medical Provider - Consent for Disclosure of Confidential Information - **RIVERSIDE ONLY** (page 19)
  Choose form(s) based on program placement (all programs fill out page 18). This form is used by Northwest Passage, LTD to seek local medical service for clients while they are residents at Northwest Passage, LTD.
- ☐ Evaluation Plan (page 20)
  This form applies only to clients entering our 30-day assessment program. All others may disregard this form.
- ☐ Informed Consent to Participate in Telemedicine Services (page 21)
- ☐ Additional Informed Consents Form (page 22)
- ☐ In a New Light Informed Consent Form (page 23)
  This form is a photography project release form.
- ☐ Outcome Tracking Consent Form (page 24)

These documents are for your review and are for you to keep as a reference during your child's placement

- ☐ Notice of Privacy Practices (pages 25-26)
- ☐ Clients Rights and Grievance Procedure (pages 27-28)
- ☐ Notice of Informed Consent (page 29)
- ☐ Program Information (review online for specific program)
- ☐ Family Policies (review online)
- ☐ Personal Possessions/Clothing List (review online)

Upon completion, this packet may be returned via email to TanyaN@nwpltd.org or via fax to 833-485-5163.

Please call Northwest Passage at 715-327-4402 if any of the forms are not included. *Packet Updated May 2019*

NORTHWEST COUNSELING AND GUIDANCE CLINIC | NORTHWEST PASSAGE, LTD
FINANCIAL INTAKE FORM

Client Information

Client Name (Last, First, Full Middle)	Date of Birth (mm/dd/yyyy)	Gender	Social Security Number

Address (street, city, state, zip code)	Place of Birth (city, county, state, country)

Financial Information

Responsible Party/Parent/Legal Guardian

Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	Gender	Social Security Number

Address (street, city, state, zip code)	Primary Phone (home, cell)

Work Phone	Fax Number	Email Address

Primary Insurance Company

Type of Insurance	☐ Medical Assistance ☐ Commercial ☐ County Funding ☐ Self Pay	☐ *Check if policy holder is same as above*

Policy Holder Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	Gender	Social Security Number

Address (street, city, state, zip code)	Primary Phone (home, cell)

Work Phone	Fax Number	Email Address

Relationship to Insured	Employer	Insurance Company	Phone

ID Number	Policy Number	Group Number	Prescription RX BIN	Prescription Rx PCN

Secondary Insurance Company

Type of Insurance	☐ Medical Assistance ☐ Commercial ☐ County Funding ☐ Self Pay	☐ *Check if secondary policy does not apply*

Policy Holder Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	Gender	Social Security Number

Address (street, city, state, zip code)	Primary Phone (home, cell)

Work Phone	Fax Number	Email Address

Relationship to Insured	Employer	Insurance Company	Phone

ID Number	Policy Number	Group Number	Prescription RX BIN	Prescription Rx PCN

Assignment of Benefits

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

_____ _____ _____

Client/Guardian Signature | Date Signed | Relationship to Client (if applicable)

Financial Responsibility

I acknowledge responsibility for full payment of this account and all charges and costs incurred by this client. Failure to pay your bill can result in your name being referred to our collection agency or Conciliation Court.

_____ _____ _____

Client/Guardian Signature | Date Signed | Relationship to Client (if applicable)

Insurance Benefits Statement

Northwest Counseling & Guidance Clinic and Northwest Passage 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.

_____ _____ _____

Client/Guardian Signature | Date Signed | Relationship to Client (if applicable)

NORTHWEST PASSAGE, LTD
MEDICAL SERVICES CONSENT - CHILD WELFARE FACILITIES

This form satisfies the requirements of form DCF-F-CFS2379-E recommend by the Department of Children & Family Services, Division of Safety and Permanence.

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, attached separate sheet(s).

A. Facility Information

Name	Telephone Number	Address (Street, City, State, Zip Code)
Northwest Passage, LTD	715.327.4402	203 United Way, Frederic, WI, 54837

B. Child Information

Name - Child (Last, First, Full Middle)	Ethnicity	Gender	Religious Affiliation (if any)	Birth Date (mm/dd/yyyy)

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

C. Parent/Legal Guardian

1. Name - Parent/Legal Guardian	2. Name - Parent/Legal Guardian
Phone (Home, Work, Other)	Phone (Home, Work, Other)
E-Mail Address (Primary)	E-Mail Address (Primary)
Address - Home (Street, City, State, Zip Code)	Address - Home (Street, City, State, Zip Code)
Address - Work (Street, City, State, Zip Code)	Address - Work (Street, City, State, Zip Code)
Address - Other (Street, City, State, Zip Code)	Address - Other (Street, City, State, Zip Code)

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

_____ _____ _____

Signature of Parent/Legal Guardian | Date Signed | Relationship to Client

(Required for all residents under 18 years of age and any resident 18 years of age or older who have been deemed incompetent by a court)

_____ _____

Resident | Date Signed

(Between 14 and 18 years of age - whenever feasible)

_____ _____

Resident | Date Signed

(18 years of age or older - Required unless resident has been deemed incompetent by a court)

NORTHWEST PASSAGE, LTD
ALLERGIC REACTIONS & CURRENT MEDICATIONS

NOTE: Client MUST arrive for admission with a supply of at least 10 days worth of all current medications. Medications must come in original prescription bottles with accurate/ current dosing information. If dosing has changed from what is listed on the prescription bottles, appropriate documentation from the physician who altered the dosing should accompany the medications.

Client Name:

Last, First, MI	Date of Birth (mm/dd/yyyy)	Address (street, city, state, zip code)	
Hair Color	Eye Color	Approx. Height	Approx. Weight

Allergic and Adverse Reactions to Medications or Foods:

Name of Medication or Food	Adverse Reaction

CURRENT MEDICATIONS:

Medication Name	Dose	Times	Reason Taking	Date Started	Notes
example: Risperdal	.5 mg	8 am, 8 pm	Mood Stabilization	08/01/2014	

Please list any special dietary needs and restrictions, physical restrictions, or other specific medical concerns:

Signature Required

Please note: *If any new psychotropic medications or changes in psychotropic medications are needed, Northwest Passage will obtain client guardian consent prior to these changes.*

I, the undersigned, hereby give permission to Northwest Passage to administer medication, including psychotropic, to my child while enrolled in the program.

Signature of Parent/Legal Guardian	Date	Relationship to Client

NORTHWEST PASSAGE, LTD
PHYSICAL EXAM & MEDICAL HEALTH HISTORY

Client Physical Exam History

State statute mandates that every child entering Northwest Passage residential programming has received a well-child general physical exam in the past 365 days. Physical exams done for hospital admissions do not count. If your child *has* had a well-child exam in the past year, please complete the information below, and attach a copy of the physical exam form. If your child *has not* had such an exam in the past year, or if we do not receive a copy of a well-child exam within two days of admission, your child will receive an exam at our local clinic. Depending upon your insurance, you may receive a bill for this service.

Client Name:

Last, First, Full Middle	Date of Birth (mm/dd/yyyy)	Address (street, city, state, zip code)

Physical Exam or Well Child Check:

Medical Clinic Name	Name of Provider	Date of Appointment

Dental Exam:

Dental Clinic Name	Name of Provider	Date of Appointment

Client Medical Health History - Current and Past

*If YES, please circle any medical problems that you feel have been significant in your child's life (list on the left) and explain the problem in the space on the right.

Description	Yes	No	If yes, explain the problems below
1. **General** (fever, chills, fatigue, weight loss or gain, seasonal allergies, concerns about puberty)			
2. **Neurological** (seizures, loss of consciousness, closed head trauma, concussions, numbness, weakness)			
3. **Ear/Nose/ Mouth/Throat** (headaches, hearing difficulties, ear infections, vision problems, contacts/glasses)			
4. **Respiratory** (asthma, cough, problems breathing with exercise)			
5. **Cardiovascular** (heart disease, chest pains, palpitations, fainting)			
6. **Gastrointestinal** (nausea, vomiting, diarrhea, constipation, abdominal pain, heartburn)			
7. **Genitourinary** (urinary problems, blood in urine, increased frequency, painful urination, bed-wetting)			
8. **Musculoskeletal** (muscle aches, joint pain, swollen joints, fractures)			
9. **Dermatology** (skin rashes, skin changes, acne, excessive dryness)			
10. Has your child ever had **Tuberculosis**?			
11. Has your child ever had a previous positive **TB skin test B**?			

Additional Comments (including medical hospitalizations, major accidents, surgeries, injuries):

_____

_____

_____

_____

NORTHWEST PASSAGE, LTD
STUDENT IMMUNIZATION RECORD - OUT-OF-STATE CLIENTS ONLY

INSTRUCTIONS TO PARENT: This form applies only to out-of-state clients. Wisconsin residents may disregard this form. COMPLETE AND RETURN TO NORTHWEST PASSAGE. Wisconsin state law requires all public and private school students to present written evidence of immunization against certain diseases within 30 school days of admission. These requirements can be waived only if Waiver for Missing Doses section is properly signed and filed with Northwest Passage. If you have questions on immunizations or how to complete this form, contact your admissions specialist or local health department.

Client Information

Last, First, Full Middle	Date of Birth (mm/dd/yyy)	Address (street, city, state, zip code)	Gender	School Year	Grade

Parent/Legal Guardian Information

Last, First, Full Middle	Primary Phone	Address (street, city, state, zip code)

Immunization History

List the **MONTH, DAY AND YEAR** your child received each of the following immunizations. **DO NOT USE A (✓) OR (✕)** except to answer the question about chickenpox, Tdap or Td. If you do not have an immunization record for this student at home, contact your doctor or public health department to obtain it.

TYPE OF VACCINE	FIRST DOSE mm/dd/yy	SECOND DOSE mm/dd/yy	THIRD DOSE mm/dd/yy	FOURTH DOSE mm/dd/yy	FIFTH DOSE mm/dd/yy
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster Check appropriate box: ☐ Tdap ☐ Td					
Polio					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Has your child had Varicella (chickenpox) disease? Check appropriate box and provide the year if known: ☐ **YES** _____ (Year) ☐ **NO or Unsure** (Vaccine required, list to right)					

Requirements

Refer to the age/grade level requirements for the current school year to determine if this student meets the requirements.

Complete Immunization Records

IF STUDENT MEETS ALL REQUIREMENTS please skip the next section and sign at bottom of form and return to admissions specialist.

Incomplete Immunization Records

IF STUDENT DOES NOT MEET ALL REQUIREMENTS please check the appropriate box below, sign at bottom and return this form to admissions specialist. PLEASE NOTE THAT INCOMPLETELY IMMUNIZED STUDENTS MAY BE EXCLUDED FROM SCHOOL IF AN OUTBREAK OF ONE OF THESE DISEASES OCCURS.

DOSES PENDING: List in Immunization History above, the date(s) of any immunizations your child has already received.

☐ Although my child has **NOT received ALL required doses of vaccine**, the FIRST DOSE(S) has/have been received. I understand that the SECOND DOSE(S) must be received by the 90th day after admission to Northwest Passage this year, and that the THIRD DOSE(S) and FOURTH DOSE(S), if required, must be received by the 30th day of the following year. I also understand that it is my responsibility to notify the school in writing each time my child receives a dose of required vaccine.

NOTE: Failure to stay on schedule and notify the school may result in court action and a fine of up to $25.00 per day of violation.

WAIVERS FOR MISSING DOSES: List in Immunization History above, the date(s) of any immunizations your child has already received.

☐ **For health reasons** this student should not receive the following immunizations: _____

Physician Name _____ Physician Signature _____ Date Signed _____

☐ **For religious reasons** this student should not receive the following immunizations: _____

☐ **For personal conviction reasons** this student should not receive the following immunizations: _____

Signature

This form is complete and accurate to the best of my knowledge. Check one: (☐ I do ☐ I do not) give permission to share my child's current immunization records and as they are updated in the future with the state registries. I understand that I may revoke this consent at any time by sending written notification to the Northwest Passage. Following the date of revocation, Northwest Passage will provide no new records or updates to any state registries.

_____ _____ _____

Signature of Parent/Legal Guardian or Adult Client | Date | Relationship to Client

MANDATORY INFORMATION RELEASES
CHECK LIST

To work effectively with your child, we need access to records from **all service providers who have previously or are currently providing services to your child or your family**. It is very important that we gather as many records as possible, even records from providers that saw your child only for a short time or a long time ago.

The following pages will allow you to list your child's **History of Current and Prior Placements and Services** and then complete a release form for each placement or service provider. You may need to make copies of some or all of the forms in order to have a form for each provider. *If you have any questions regarding these forms, please contact your admissions specialist.*

Page 8: History of Current and Prior Placements and Services
This form should be completed for all current and prior placement and services

Page 9*: Medical Information
This form should be completed for medical providers (i.e. pediatrician, endocrinologist, cardiologist, etc.)

Page 10*: School Information
This form should be completed for any current educational institution(s)

Pages 11-14*: Additional Information
These four pages are all the same. Please fill out a release for all of the following that apply to your child (see below). Make additional copies as needed.

*All checkbox options on the release forms in this packet have been pre-checked for ease of completion. The options checked allow all records from a given provider to be released for all dates of service that provider worked with your child. If you are comfortable with the pre-checked options, you can leave them and simply complete the remaining fields. You can electronically de-select anything that is pre-checked. You may also request a blank copy of any release form without any pre-selections made. To request a blank copy, contact Tanya Nelson at 715-327-7122 or via email at TanyaN@nwpltd.org.

PLEASE CHECK EACH AREA UPON COMPLETION

- ☐ All current and/or previous **therapists or psychologists**
- ☐ All current and/or previous **day treatment programs**
- ☐ All current and/or **previous psychiatrists**
- ☐ One form for all previous **out-of-home placements** (including inpatient hospitalizations)

Please use one of the blank forms to make more copies if more are needed.

NORTHWEST PASSAGE, LTD
HISTORY OF CURRENT & PRIOR PLACEMENTS AND SERVICES

To facilitate your child/client's assessment/treatment, we need a complete record of previous interventions related to your child/client and their 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 (psychiatry, therapy/counseling, day treatment, IOP/PHP, in-home services). Additionally, please complete a release of information for each of these providers, found later in the packet.

Client Name:		
Last, First, Full Middle	Date of Birth (mm/dd/yyyy)	Address (street, city, state, zip code)

Prior Out-of-Home Placements (residential treatment, psychiatric hospitalization, foster care, group home, shelter care, correctional)

Facility	Dates of Placement	Reason for Placement	Response to Placement
Example: Any Town Medical Center	08/05/2014 - 08/10/2014	Self-harm (cutting arm)	Stabilized, discharged to partial hospital

Out Patient Evaluations and Services (psychiatry, therapy/counseling, day treatment, IOP/PHP, in-home services)

Type of Service	Provider/Agency Name	Dates of Service	Response to Services
Example: Individual Therapy	Jane Doe, MA	Aug 2014 - Nov 2014	Client did not participate

Please continue on extra page(s) if necessary

NORTHWEST PASSAGE, LTD

MEDICAL - AUTHORIZATION FOR RELEASE OF PATIENT-IDENTIFIABLE HEALTH INFORMATION

Client Name:

Last, First, Full Middle	Date of Birth (mm/dd/yyyy)	Address (street, city, state, zip code)

Authorizes:

Northwest Passage, LTD 203 United Way, Frederic, WI 54837	Northwest Counseling & Guidance Clinic 203 United Way, Frederic, WI 54837	Northwest Pediatric Specialties 203 United Way, Frederic, WI 54837

To Use, Exchange, and Disclose Information With:

Name of General Medical Provider & Clinic	Address (street, city, state, zip code)	Contact Info (phone, fax)

Records to be Disclosed (please uncheck any items that you don't wish to disclose):

- ☑ Intake/Initial Assessment
- ☑ History and Physical
- ☑ Emergency Room Records
- ☑ Progress Notes
- ☑ Diagnosis
- ☑ Discharge Summary
- ☑ Consultations
- ☑ Operative Reports
- ☑ Treatment Plan
- ☑ X-Ray
- ☑ EKG/EEG
- ☑ Labs
- ☑ Medications
- ☑ Verbal/Written Communication
- ☑ Appointment Information
- ☑ Immunizations
- ☑ Well Child Check

Release Explanations and Conditions (please check):

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

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:

- ☑ Coordinating Care/Treatment
- ☐ Transfer of Care
- ☑ Case Management
- ☐ Personal
- ☐ Billing, collection, or payment of claims
- ☐ Other

Disclosure Notices:

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/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 notify Northwest Passage 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.

F. Signatures

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) Date

_____ _____ _____

Signature of Parent/Legal Guardian Date Relationship to Client

NORTHWEST PASSAGE, LTD

SCHOOL - AUTHORIZATION FOR RELEASE OF PATIENT-IDENTIFIABLE HEALTH INFORMATION

Client Name:		
Last, First, Full Middle	Date of Birth (mm/dd/yyyy)	Address (street, city, state, zip code)

Authorizes:		
Northwest Passage, LTD 203 United Way Frederic, WI 54837	Northwest Counseling & Guidance Clinic 203 United Way Frederic, WI 54837	Northwest Pediatric Specialties 203 United Way Frederic, WI 54837

To Use, Exchange, and Disclose Information With:		
Name of Your Child's School	Address (street, city, state, zip code)	Contact Info (phone, fax)

Records to be Disclosed (please uncheck any items that you don't wish to disclose):

- ☒ Transcripts
- ☒ Teacher/Counselor Records
- ☒ Acknowledgment of Admission
- ☒ Verbal/Written Communication
- ☒ I.E.P., M-Team Documents
- ☒ Psychological/Psycho-Educational Reports
- ☒ Present Grade/Last Grade Completed
- ☒ Standardized Test Scores
- ☒ Immunizations
- ☐ Other

Release Explanations and Conditions (please check):

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

Time Period for which records are requested: From _____ to_____ ☒ ALL

Expiration: This authorization will remain in effect:	**Reason for Release:**
☐ From the date this authorization is signed until: _____	☒ Coordinating Care/Treatment
☒ One year from the date of signature	☐ Transfer of Care
☐ Until I cancel this authorization in writing	☒ Case Management
☐ Other, specify: _____	☐ Personal
	☐ Billing, collection, or payment of claims
	☐ Other

Disclosure Notices:

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/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.

F. Signatures

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) Date

_____ _____ _____

Signature of Parent/Legal Guardian Date Relationship to Client

NORTHWEST PASSAGE, LTD

MENTAL HEALTH - AUTHORIZATION FOR RELEASE OF PATIENT-IDENTIFIABLE HEALTH INFORMATION

Client Name:

Last, First, Full Middle	Date of Birth (mm/dd/yyyy)	Address (street, city, state, zip code)

Authorizes:

Northwest Passage, LTD 203 United Way Frederic, WI 54837	Northwest Counseling & Guidance Clinic 203 United Way Frederic, WI 54837	Northwest Pediatric Specialties 203 United Way Frederic, WI 54837

To Use, Exchange, and Disclose Information With:

Mental Health Provider (clinic or agency)	Address (street, city, state, zip code)	Contact Info (phone, fax)

Records to be Disclosed (please uncheck any items that you don't wish to disclose):

- ☒ Mental Health Treatment Records
  - ☒ Intake/Initial Assessment
  - ☒ Progress Notes
  - ☒ Treatment Plan
  - ☒ Discharge Summary
- ☒ Alcohol/Drug Treatment Records
- ☒ Acknowledgments of Admission
- ☒ Medical Evaluation/Health Records
- ☒ Psychiatric Evaluations
- ☒ Psychological Evaluations/Test Results
- ☒ Human Service Records
- ☒ Verbal/Written Communication
- ☒ Educational Records
  - ☒ Standardized Test Scores
  - ☒ Teacher/Counselor/Social Worker Records
- ☒ Appointment Information
- ☐ Other: _____

Release Explanations and Conditions (please check):

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

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:

- ☒ Coordinating Care/Treatment
- ☐ Transfer of Care
- ☒ Case Management
- ☐ Personal
- ☐ Billing, collection, or payment of claims
- ☐ Other

Disclosure Notices:

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/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.

F. Signatures

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) Date

_____ _____ _____

Signature of Parent/Legal Guardian Date Relationship to Client

NORTHWEST PASSAGE, LTD

MENTAL HEALTH - AUTHORIZATION FOR RELEASE OF PATIENT-IDENTIFIABLE HEALTH INFORMATION

Client Name:

Last, First, Full Middle	Date of Birth (mm/dd/yyyy)	Address (street, city, state, zip code)

Authorizes:

Northwest Passage, LTD 203 United Way Frederic, WI 54837	Northwest Counseling & Guidance Clinic 203 United Way Frederic, WI 54837	Northwest Pediatric Specialties 203 United Way Frederic, WI 54837

To Use, Exchange, and Disclose Information With:

Mental Health Provider (clinic or agency)	Address (street, city, state, zip code)	Contact Info (phone, fax)

Records to be Disclosed (please uncheck any items that you don't wish to disclose):

- ☒ Mental Health Treatment Records
  - ☒ Intake/Initial Assessment
  - ☒ Progress Notes
  - ☒ Treatment Plan
  - ☒ Discharge Summary
- ☒ Alcohol/Drug Treatment Records
- ☒ Acknowledgments of Admission
- ☒ Medical Evaluation/Health Records
- ☒ Psychiatric Evaluations
- ☒ Psychological Evaluations/Test Results
- ☒ Human Service Records
- ☒ Verbal/Written Communication
- ☒ Educational Records
  - ☒ Standardized Test Scores
  - ☒ Teacher/Counselor/Social Worker Records
- ☒ Appointment Information
- ☐ Other: _____

Release Explanations and Conditions (please check):

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

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:

- ☒ Coordinating Care/Treatment
- ☐ Transfer of Care
- ☒ Case Management
- ☐ Personal
- ☐ Billing, collection, or payment of claims
- ☐ Other

Disclosure Notices:

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/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.

F. Signatures

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) Date

_____ _____ _____

Signature of Parent/Legal Guardian Date Relationship to Client

NORTHWEST PASSAGE, LTD

MENTAL HEALTH - AUTHORIZATION FOR RELEASE OF PATIENT-IDENTIFIABLE HEALTH INFORMATION

Client Name:		
Last, First, Full Middle	Date of Birth (mm/dd/yyyy)	Address (street, city, state, zip code)

Authorizes:		
Northwest Passage, LTD 203 United Way Frederic, WI 54837	Northwest Counseling & Guidance Clinic 203 United Way Frederic, WI 54837	Northwest Pediatric Specialties 203 United Way Frederic, WI 54837

To Use, Exchange, and Disclose Information With:		
Mental Health Provider (clinic or agency)	Address (street, city, state, zip code)	Contact Info (phone, fax)

Records to be Disclosed (please uncheck any items that you don't wish to disclose):

- ☒ Mental Health Treatment Records
  - ☒ Intake/Initial Assessment
  - ☒ Progress Notes
  - ☒ Treatment Plan
  - ☒ Discharge Summary
- ☒ Alcohol/Drug Treatment Records
- ☒ Acknowledgments of Admission
- ☒ Medical Evaluation/Health Records
- ☒ Psychiatric Evaluations
- ☒ Psychological Evaluations/Test Results
- ☒ Human Service Records
- ☒ Verbal/Written Communication
- ☒ Educational Records
  - ☒ Standardized Test Scores
  - ☒ Teacher/Counselor/Social Worker Records
- ☒ Appointment Information
- ☐ Other: _____

Release Explanations and Conditions (please check):

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

Time Period for which records are requested: From _____ to_____ ☒ ALL

Expiration: This authorization will remain in effect:	**Reason for Release:**
☐ From the date this authorization is signed until: _____ ☒ One year from the date of signature ☐ Until I cancel this authorization in writing ☐ Other, specify: _____	☒ Coordinating Care/Treatment ☐ Transfer of Care ☒ Case Management ☐ Personal ☐ Billing, collection, or payment of claims ☐ Other

Disclosure Notices:

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/other information is NOT sufficient for this purpose.

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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.
- 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.

F. Signatures

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) Date

_____ _____ _____

Signature of Parent/Legal Guardian Date Relationship to Client

NORTHWEST PASSAGE, LTD

MENTAL HEALTH - AUTHORIZATION FOR RELEASE OF PATIENT-IDENTIFIABLE HEALTH INFORMATION

Client Name:		
Last, First, Full Middle	Date of Birth (mm/dd/yyyy)	Address (street, city, state, zip code)

Authorizes:		
Northwest Passage, LTD 203 United Way Frederic, WI 54837	Northwest Counseling & Guidance Clinic 203 United Way Frederic, WI 54837	Northwest Pediatric Specialties 203 United Way Frederic, WI 54837

To Use, Exchange, and Disclose Information With:		
Mental Health Provider (clinic or agency)	Address (street, city, state, zip code)	Contact Info (phone, fax)

Records to be Disclosed (please uncheck any items that you don't wish to disclose):

- ☒ Mental Health Treatment Records
  - ☒ Intake/Initial Assessment
  - ☒ Progress Notes
  - ☒ Treatment Plan
  - ☒ Discharge Summary
- ☒ Alcohol/Drug Treatment Records
- ☒ Acknowledgments of Admission
- ☒ Medical Evaluation/Health Records
- ☒ Psychiatric Evaluations
- ☒ Psychological Evaluations/Test Results
- ☒ Human Service Records
- ☒ Verbal/Written Communication
- ☒ Educational Records
  - ☒ Standardized Test Scores
  - ☒ Teacher/Counselor/Social Worker Records
- ☒ Appointment Information
- ☐ Other: _____

Release Explanations and Conditions (please check):

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

Time Period for which records are requested: From _____ to_____ ☒ ALL

Expiration: This authorization will remain in effect:	**Reason for Release:**
☐ From the date this authorization is signed until: _____ ☒ One year from the date of signature ☐ Until I cancel this authorization in writing ☐ Other, specify: _____	☒ Coordinating Care/Treatment ☐ Transfer of Care ☒ Case Management ☐ Personal ☐ Billing, collection, or payment of claims ☐ Other

Disclosure Notices:

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/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.

F. Signatures

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) Date

_____ _____ _____

Signature of Parent/Legal Guardian Date Relationship to Client

NORTHWEST PASSAGE, LTD
WISCONSIN MEDICAL ASSISTANCE - RELEASE OF INFORMATION AUTHORIZATION

THIS FORM IS FOR WISCONSIN MEDICAL ASSISTANCE RECIPIENTS ONLY: This form is used by Northwest Passage, LTD to seek local medical service for clients while they are residents at Northwest Passage, LTD.

Client Name:

Last, First, Full Middle	Date of Birth (mm/dd/yyyy)	Address (street, city, state, zip code)

Authorizes:

Northwest Passage, LTD 203 United Way, Frederic, WI 54837	Northwest Counseling & Guidance Clinic 203 United Way, Frederic, WI 54837	Northwest Pediatric Specialties 203 United Way, Frederic, WI 54837

To Use, Exchange, and Disclose Information With:

Name of Person/Organization	Address (street, city, state, zip code)
Medical Assistance/EDS	**6406 Bridge Road, Madison, WI 53784**

Records to be Disclosed (please uncheck any items that you don't wish to disclose):

- ☒ Alcohol/Drug Treatment Records
  - ☒ Intake/Initial Assessment
  - ☒ Progress Notes
  - ☒ Treatment Plan
  - ☒ Discharge Summary
- ☒ Alcohol/Drug Treatment Records
- ☒ Acknowledgments of Admission
- ☒ Medical Evaluation/Health Records
- ☒ Psychiatric Evaluations
- ☒ Psychological Evaluations/Test Results
- ☒ Human Service Records
- ☒ Verbal/Written Communication
- ☒ Educational Records
  - ☒ Standardized Test Scores
  - ☒ Teacher/Counselor/Social Worker Records
- ☒ Appointment Information
- ☐ Other: _____

Release Explanations and Conditions (please check):

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

- ☒ Coordinating Care/Treatment
- ☐ Transfer of Care
- ☒ Case Management
- ☐ Personal
- ☐ Billing, collection, or payment of claims
- ☐ Other

Disclosure Notices:

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/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.

F. Signatures

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) Date

_____ _____ _____
Signature of Parent/Legal Guardian Date Relationship to Client

NORTHWEST PASSAGE, LTD
COMMERCIAL INSURANCE - RELEASE OF INFORMATION AUTHORIZATION

Client Name:

Last, First, Full Middle	Date of Birth (mm/dd/yyyy)	Address (street, city, state, zip code)

Authorizes:

Northwest Passage, LTD 203 United Way, Frederic, WI 54837	Northwest Counseling & Guidance Clinic 203 United Way, Frederic, WI 54837	Northwest Pediatric Specialties 203 United Way, Frederic, WI 54837

To Use, Exchange, and Disclose Information With Commercial Insurance Provider:

Name of Commercial Insurance Provider	Address (street, city, state, zip code)	Contact Info (phone, fax, email)

Records to be Disclosed (please uncheck any items that you don't wish to disclose):

- ☒ Mental Health Treatment Records
  - ☒ Intake/Initial Assessment
  - ☒ Progress Notes
  - ☒ Treatment Plan
  - ☒ Discharge Summary
- ☒ Alcohol/Drug Treatment Records
- ☒ Acknowledgments of Admission
- ☒ Medical Evaluation/Health Records
- ☒ Psychiatric Evaluations
- ☒ Psychological Evaluations/Test Results
- ☒ Human Service Records
- ☒ Verbal/Written Communication
- ☒ Educational Records
  - ☒ Standardized Test Scores
  - ☒ Teacher/Counselor/Social Worker Records
- ☒ Appointment Information
- ☐ Other: _____

Release Explanations and Conditions (please check):

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

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:

- ☒ Coordinating Care/Treatment
- ☐ Transfer of Care
- ☒ Case Management
- ☐ Personal
- ☐ Billing, collection, or payment of claims
- ☐ Other

Disclosure Notices:

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/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.

F. Signatures

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) Date

_____ _____ _____

Signature of Parent/Legal Guardian Date Relationship to Client

NORTHWEST PASSAGE, LTD
INTER-AGENCY - CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Inter-agency Consent Explanation

This form allows all legal entities within the Northwest system to communicate with one another internally.

Client Name:

Last, First, Full Middle	Date of Birth (mm/dd/yyyy)	Address (street, city, state, zip code)

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

Northwest Passage, LTD 203 United Way, Frederic, WI 54837	Northwest Counseling & Guidance Clinic 203 United Way, Frederic, WI 54837	Northwest Pediatric Specialties 203 United Way, Frederic, WI 54837

Records to be Disclosed (please uncheck any items that you don't wish to disclose):

- ☒ Mental Health Treatment Records
  - ☒ Intake/Initial Assessment
  - ☒ Progress Notes
  - ☒ Treatment Plan
  - ☒ Discharge Summary
- ☒ Alcohol/Drug Treatment Records
- ☒ Acknowledgments of Admission
- ☒ Medical Evaluation/Health Records
- ☒ Psychiatric Evaluations
- ☒ Psychological Evaluations/Test Results
- ☒ Human Service Records
- ☒ Verbal/Written Communication
- ☒ Educational Records
  - ☒ Standardized Test Scores
  - ☒ Teacher/Counselor/Social Worker Records
- ☒ Appointment Information
- ☐ Other: _____

Release Explanations and Conditions (please check):

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

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:

- ☒ Coordinating Care/Treatment
- ☐ Transfer of Care
- ☒ Case Management
- ☐ Personal
- ☐ Billing, collection, or payment of claims
- ☐ Other

Disclosure Notices:

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/other information is NOT sufficient for this purpose.

Your Rights with Respect to this Authorization:

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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.
- 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.

F. Signatures

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) Date

_____ _____ _____

Signature of Parent/Legal Guardian Date Relationship to Client

NORTHWEST PASSAGE, LTD

LOCAL MEDICAL PROVIDER - CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

This form is used by Northwest Passage, LTD to seek local medical service for clients while they are residents at Northwest Passage, LTD.

Client Name:

Last, First, Full Middle	Date of Birth (mm/dd/yyyy)	Address (street, city, state, zip code)

Authorizes:

Agency Name	Address (street, city, state, zip code)	Phone Number
Northwest Passage, LTD	203 United Way, Frederic, WI 54837	715-327-4402

To Use, Exchange, and Disclose Information With:

Name of Person/Organization	Address (street, city, state, zip code)	Contact Info (phone, fax)
St. Croix Regional Medical Center	**208 South Adams St., St. Croix Falls, WI 54024**	**715-483-3221, 715-483-0507**

Records to be Disclosed (please uncheck any items that you don't wish to disclose):

☒ Intake/Initial Assessment	☒ Diagnosis	☒ Treatment Plan	☒ Medications
☒ History and Physical	☒ Discharge Summary	☒ X-Ray	☒ Verbal/Written Communication
☒ Emergency Room Records	☒ Consultations	☒ EKG/EEG	☒ Appointment Information
☒ Progress Notes	☒ Operative Reports	☒ Labs	☒ Immunizations

Release Explanations and Conditions (please check):

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

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:

- ☒ Coordinating Care/Treatment
- ☐ Transfer of Care
- ☒ Case Management
- ☐ Personal
- ☐ Billing, collection, or payment of claims
- ☐ Other

Disclosure Notices:

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/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.

F. Signatures

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) Date

_____ _____ _____

Signature of Parent/Legal Guardian Date Relationship to Client

NORTHWEST PASSAGE, LTD
LOCAL MEDICAL PROVIDER - CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

This form is used by Northwest Passage, LTD to seek local medical service for clients while they are residents at Northwest Passage, LTD.

Client Name:

Last, First, Full Middle	Date of Birth (mm/dd/yyyy)	Address (street, city, state, zip code)

Authorizes:

Agency Name	Address (street, city, state, zip code)	Phone Number
Northwest Passage, LTD	203 United Way, Frederic, WI 54837	715-327-4402

To Use, Exchange, and Disclose Information With:

Name of Person/Organization	Address (street, city, state, zip code)	Contact Info (phone, fax)
Burnett Medical Center	**257 W. St. George Ave, Grantsburg, WI 54840**	**715-463-5353, 715-463-2753**

Records to be Disclosed (please uncheck any items that you don't wish to disclose):

☒ Intake/Initial Assessment	☒ Diagnosis	☒ Treatment Plan	☒ Medications
☒ History and Physical	☒ Discharge Summary	☒ X-Ray	☒ Verbal/Written Communication
☒ Emergency Room Records	☒ Consultations	☒ EKG/EEG	☒ Appointment Information
☒ Progress Notes	☒ Operative Reports	☒ Labs	☒ Immunizations

Release Explanations and Conditions (please check):

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

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:

- ☒ Coordinating Care/Treatment
- ☐ Transfer of Care
- ☒ Case Management
- ☐ Personal
- ☐ Billing, collection, or payment of claims
- ☐ Other

Disclosure Notices:

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/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.

F. Signatures

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) Date

_____ _____ _____

Signature of Parent/Legal Guardian Date Relationship to Client

NORTHWEST COUNSELING AND GUIDANCE CLINIC
EVALUATION PLAN FOR ASSESSMENT CLIENTS

This form applies to clients entering our **30-DAY ASSESSMENT PROGRAM ONLY**. All others may disregard this form. In order to provide clinical services, state regulations require that we have the equivalent of a "treatment plan" on file. This Evaluation Plan serves that purpose and only requires the signature of a parent/Legal Guardian. Please sign on the indicated line.

Assessment Client Name

Last, First, Full Middle	Date of Birth (mm/dd/yyyy)	Address (street, city, state, zip code)

For Office Use Only

FOR OFFICE USE ONLY

Assessment Intake Date	Assessment Start Date

Mental Health Professionals (the professionals providing services)

Therapist

Neuropsychologist

AODA Therapist

NOTE:
Presenting Problem (please see final evaluation report)
Evaluation Plan (patient will comply with clinical interviews and testing as needed for this evaluation)
Signatures (professional signatures only)

_____ Mental Health Therapist Signature	_____ Date
_____ Neuropsychologist Signature	_____ Date
_____ AODA Therapist Signature	_____ Date
_____ Clinical Supervisor Signature (only applicable for AODA)	_____ Date
_____ Physician Signature	_____ Date
_____ Psychiatrist Signature	_____ Date

Signatures

_____ Signature of Client (Required for age 12 & over for AODA)	_____ Date	
_____ Signature of Parent/Legal Guardian	_____ Date	_____ Relationship to Client

NORTHWEST COUNSELING AND GUIDANCE CLINIC
INFORMED CONSENT TO PARTICIPATE IN TELEMEDICINE SERVICES

I, _____, have been asked to receive mental health services via TeleHealth. I understand that I will be receiving health care services through interactive videoconferencing equipment. The TeleHealth Coordinator or another staff member of Northwest has explained to me how the videoconferencing technology will be used to provide such services to me. I understand that my TeleHealth sessions will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

I understand that my participation in TeleHealth is voluntary, and that I have the right to refuse to take part, limit, or to stop taking part in TeleHealth interactions at any time without affecting my care, now or in the future, at Northwest. I further understand that I do not have to take part in TeleHealth to receive services from Northwest.

The benefits of TeleHealth have been explained to me, including:
- Improved access to healthcare services and providers.
- Reduced travel for healthcare.
- Increased convenience.
- Focused healthcare information.

I have also been advised that there are potential risks to this technology. These risks may include:
- The audio/video connection may fail to work or may be interrupted or become disconnected during the consultation.
- The interactive connection may not provide a picture that is clear enough to meet the needs of the consultation.
- There is a small chance that someone could access the consultation through the interactive connection by electronic tampering. The transmission is designed to fail should anyone attempt to electronically eavesdrop during the appointment. However, there is always the remote possibility of security or technical failures.

I understand that the health care providers at both my location and the remote site will have access to any relevant health information about me including any psychiatric and/or psychological information, alcohol and/or drug abuse information, and mental health records. I also understand that individuals may be present at either location to operate the audio/video equipment and that these individuals must maintain confidentiality of health care information to which they become privy, and I consent to their presence.

I understand that my personal information will be held in strict confidence, and shared only on a need-to-know basis, and even then only the minimum information necessary will be disclosed.

I understand that there will be confidential records of my TeleHealth sessions(s) maintained by Northwest and that I have the right to inspect all information transmitted during a TeleHealth session or consultation, and may receive copies of this information for a reasonable fee.

I understand that there may be follow-up TeleHealth sessions, but if at any time during my TeleHealth sessions I do not wish to participate, I have the right to refuse to take part in TeleHealth interactions.

I understand that I may be asked to give separate consent for client photographs, videorecording and/or audio recording taken during my TeleHealth session or consultation.

I understand that I must give my informed consent to participate in TeleHealth and receive TeleHealth services. I further understand that I will not receive any royalties or other compensation for taking part in TeleHealth sessions or for the authorized use of any consultation images or audio.

I understand that, if a psychiatrist or a certified clinician believes that I am a danger to myself or others or unable to care for myself, then I may be sent to an evaluation facility involuntarily.

I understand that, if I threaten to harm an identifiable person or government official, a clinician is required to warn that person and inform law enforcement.

I understand that, if a clinician suspects abuse or serious neglect of a child, helpless adult, or senior citizen, a report must be made to the designated agency within 24 hours and permission is not required.

I certify that this form and the purposes and processes of TeleHealth services have been fully explained to me and I have read and understand this form or have had it read to me. I understand the risks and benefits of TeleHealth technology and services. I agree to participate in the TeleHealth services offered by Northwest and I consent to receive mental health services and consultation via TeleHealth.

This informed consent will remain in force and effect for a period of fifteen (15) months from the date below, unless I provide a written notice of the withdrawal of this consent.

_____ _____
Client Signature (age 14 and over) Date

_____ _____
Legal Guardian Signature Date

Additional Informed Consents Form

Name of Client: _____ DOB: _____

Please initial each item:

Parent / Client

_____ / _____ I have received a copy of the privacy statement and understand that this statement applies to NWP, NWCGC, and NWPeds.

_____ / _____ 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.

_____ / _____ I acknowledge that I have received a copy of my rights to Informed Consent to Treatment. I have read and understand the rights afforded to me under that consent.

_____ / _____ I have read and understand the Program Information and Family Policies provided to me.

_____ / _____ I am aware that employees of Northwest Passage are mandatory reporters of abuse. During therapy, limited confidentiality is provided to the resident. Disclosure of events (past or current) that involved physical or sexual abuse, either as a victim or perpetrator, will be reported to authorities for investigation.

_____ / _____ I give permission for my child to receive haircuts as needed.

_____ / _____ I give permission for my child to attend field trips, community service trips and restitution activities.

_____ / _____ I give my permission for my child to be transported by the agency as needed to off site appointments, school, activities, etc.

_____ / _____ I give permission for my child/client to use power tools while in the NWP Riverside vocational curriculum (if applicable) under the supervision of NWP instructors (for Riverside clients only).

_____ / _____ I understand my child/client may come into contact with animals in a variety of therapeutic activities under direct supervision of staff.

_____ / _____ I understand that Northwest Passage is not a religiously affiliated organization/program. Decisions regarding any personal religious involvement will be made on a case by case basis. While attendance at local religious services may be desirable, the availability for this will always be based on resident and program needs. I would like the program to be aware of the following denominational preference for my child: _____.

_____ / _____ I give permission for Northwest Passage to use photographs or videos taken of my child for potential use in brochures, newsletters, and promotional videos, and for recognition in newspapers, magazines, television, or film. These photos and videos may also be shared to reflect on the positive experiences of the program, to display program activities, or in recognition of accomplishments. Northwest Passage operates within the confidentiality guidelines of HFS 92.03(c). As such, we will not use photographs or videos of residents for out of program use without permission of parent or guardian. Northwest Passage also does not identify the last names of the residents in these photographs and videos.

I consent to the items as noted above and I understand that this consent can be revoked at any time. With the exception of the consent for contact related to outcome tracking post discharge, I understand that this consent will expire at date of discharge.

_____ _____

Client Signature (Required for 14 & over) Date

_____ _____ _____

Signature of Parent/Legal Guardian Date Relationship to Client

In a New Light Informed Consent Form

In a New Light is therapeutic nature photography programming at Northwest Passage. **In a New Light** immerses residents in a photographic journey of discovery, hope, and healing through their experience on local trails and rivers. This release is necessary for your child to participate in the **In a New Light** programming.

Agreement and Release for the **In a New Light** Photography Programming

Client Name: _____ D.O.B.: _____

I, as the parent/legal guardian, agree to allow my child to participate in the photography program offered by and through Northwest Passage, Ltd. I understand that all photographic content my child creates remains the property of both Northwest Passage and my child. Northwest Passage retains the perpetual right to create unlimited digital, print, and video reproductions of all photographs, and I waive the right to any compensation, monetary or otherwise, to which I, or my child, might otherwise be entitled. Upon completion of the Northwest Passage program my son or daughter will receive a CD or flash drive of all photos they have taken throughout the photography program, and they may use these photos in any manner they wish. Furthermore, I release Northwest Passage, Ltd, its subsidiaries, agents and assigns from any claims, demands, actions, causes of action or suits arising from my child's participation in this program.

The undersigned hereby declares that the terms of this settlement have been completely read and are fully understood and voluntarily accepted for the purpose of making a full and final settlement of any and all claims arising out of the aforementioned program.

Please check one of the following options:

_____ I understand and agree to the above statements and will allow my child to participate in the In a New Light programming

_____ I do not wish for my child to participate in this voluntary programming at this time.

_____ _____ _____

Signature of Parent/Legal Guardian Date Relationship to Client

Outcome Tracking Consent Form

Northwest Passage is interested in evaluating our treatment program and tracking your child's progress at Northwest Passage, as well as how he/she is doing following discharge. You and your child are invited to participate in the collection of this data. The data we collect will assist us in evaluating our treatment program, assessing treatment outcomes of the clients we serve, and can be used to improve our services and provide better help to children and adolescents at Northwest Passage.

You and your child will be asked to complete a questionnaire at intake, discharge, and post discharge. The questionnaires will take approximately 15-20 minutes (each) to complete and can be completed online or via forms that can be mailed out to you. These questionnaires will ask questions about your perception and your child's perception of their behavior, mood, over-all mental health and functioning.

Completing the questionnaires is voluntary and free of cost. Should you choose to not participate there will be no prejudice, penalty, or loss of benefits to you or your child. Identifying information will not be shared with anyone other than Northwest Passage staff.

By signing below, I am indicating I have read the above information and understand Northwest Passage may ask me and my child to complete and return questionnaires while my child is at their program and following their discharge from the program.

Client:

_____ _____

Client's Signature Print Client's Name

Parent/Legal Guardian #1:

_____ _____

Parent/Legal Guardian Signature Print Parent/Legal Guardian Name

Parent/Legal Guardian #2:

_____ _____

Parent/Legal Guardian Signature Print Parent/Legal Guardian Name

NORTHWEST PASSAGE, LTD
NOTICE OF PRIVACY PRACTICES (PAGE 1 OF 2)

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

NORTHWEST PASSAGE, LTD
NOTICE OF PRIVACY PRACTICES (PAGE 2 OF 2)

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, Frederic, WI 54837

Phone number: 715-327-4402 | Fax number: 715-327-4470 | Email address: CareyL@nwpltd.org

Effective Date: This Notice of Privacy Practice became effective as of April 14, 2003. It is reviewed and updated annually.

IMPORTANT NOTE: Due to our affiliation with both Northwest Counseling and Guidance Clinic (NWCGC) and Northwest Pediatric Specialties (NW Peds), 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.

Please retain this notice for your records. Your are requested to initial the appropriate section on the Additional Informed Consents page of this packet as an acknowledgment that you received this notification. Thank you.

Please retain for your records

NORTHWEST PASSAGE, LTD
CLIENT BILL OF RIGHTS AND THE GRIEVANCE PROCEDURE (PAGE 1 OF 2)

Below is the Bill of Rights given to the client at the time of intake. The Bill of Rights is in accordance to Wisconsin Statue 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 Statue 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 you 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:
Anna Pearson | Address: **203 United Way, 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.

Please retain for your records

NORTHWEST COUNSELING AND GUIDANCE CLINIC | NORTHWEST PASSAGE, LTD
NOTICE OF INFORMED CONSENT

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 Passage and Northwest Counseling and Guidance Clinic are 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 program within the system, the originating program may provide copies of treatment records pertinent to ongoing care to the receiving 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 on the Additional Informed Consents.

Please retain for your records