GJB Health Services, LLC
711 N Lynndale Dr., Suite 1A
Appleton, WI 54914
P: (920) 560 – 4525
F: (920) 560-6618

Office Use Only:	**INITIALS / DATE**
EHR Verification	_____
Rx/Allergies	_____
Scanned	_____
Chart Created	_____

New Client Registration

Last Name _____ First _____ M.I. _____ Sex: M / F / O: _____

Date of Birth _____ Age_____

Address _____ City _____ State _____ Zip_____

Primary Contact (_____) _____ May we leave a voicemail/message at this number? Y / N

Owner of Primary Contact #, if not Patient _____ Relationship to Patient _____

Appointment Reminders (48 hours in advance): __ Phone Call/Leave Voicemail __ Text Message __ Email

SSN _____-_____-_____ Email _____

Insurance Information		
	Primary Insurance	**Secondary Insurance**
Ins. Co.		
Member #		
Group #		
Primary Policy Holder		
Primary's DOB		

Assignment & Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to GJB Health Services, LLC all insurance benefits, if any, otherwise payable to me, for services rendered.

I understand and agree that I am financially responsible for all charges, legal or clinical, whether or not paid by insurance. I hereby authorize the provider and all employees of GJB Health Services, LLC to release any and all information necessary, printed or verbal to secure the payment of benefits. I authorize the use of this signature on all claims (manual or electronic).

_____ _____

Patient Signature/Parent/Guardian Date

Financial Responsibility Consent

Client Name	
Responsible Party (if different than Client)	
Responsible Party's Contact #	( ) -
Responsible Party's Address	

- **PAYMENT AT THE TIME OF SERVICE.**
  - **Payment is expected at the time of service to satisfy deductibles, coinsurances, copays, or any private payments.** Payment may be made with a credit or debit card, check, or cash.
  - **An *estimated* payment amount is the required payment at the time of service. Payments are based on:**
    - Yearly reimbursement schedules
    - Previously received Explanation of Benefits (EOBs) from insurance companies
  - GJB Health Services understands this is an *estimated* amount. Clients will receive prompt reimbursement for overages, once payment is received from insurance. Insurance payments range from days to roughly 4-6 weeks.
  - **Insurance claims are filed as a courtesy to clients; clients are responsible for all charges,** if insurance does not pay the claim.
- **OUTSIDE OFFICE PAYMENT.**
  - Contact the office via phone to pay via credit card.
  - Send check via mail.
- **NOTIFICATION OF BALANCES / PATIENT PORTAL.**
  - It is understood that account balances are electronically monitored, via GJB's *Patient Portal*.
  - **Contact: GJBHealthServices@gmail.com or the front office and kindly request a portal registration.**
    - Communicate with providers, renew prescriptions, request appointments, and find trusted health information.
  - Hard copy statements are only provided upon request.
  - GJB Health Services may directly contact clients to address or satisfy unpaid balances.
  - GJB Health Services reserves the right to **forward past due balances to outside collection agencies**.
    - Clients must deal directly with collection agencies at that point.
- **NO SHOW CHARGES.**
  - 24 hours' notice will be provided when changing existing appointments.
  - It is understood that Missed Appointments or Late Cancellations, without an immediate Reschedule, are subject to private charges.
    - **$150.00 per Missed Appointment or Late Cancelation will apply for appointments with all GJB Health Services providers.**
  - It is understood that no GJB Health Services provider can be seen without payment for missed appointment(s).
  - GJB Health Services reserves the right to terminate services after 2+ consecutively missed appointments.
    - Notification will be provided via a mailed letter.
- **LEGAL FEES.**
  - Legal testimony / reports are billed directly to those listed above, as insurance does not cover these services.
    - 150.00 for each report / $100.00 per conversation with court representatives.

I, the undersigned, agree to abide by the above stated financial policies. Copy of this document can be provided upon request.

_____ _____

Client / Parent / Guardian Signature Date

In Case of Emergencies
EMERGENCY CONTACT NAME _____

Phone (_____) _____

Alternate Phone if need be (_____) _____

Address, City, & State _____

Relationship of Contact to Client _____

Additional Contact Information

I give my permission to GJB Health Services, LLC to contact the above person(s) in the following circumstances: Please initial where applicable.

_____ If I fail to appear for a scheduled appointment and GJB Health Services, LLC is unable to reach me by telephone.

_____ If there is reason for GJB Health Services, LLC to be concerned about my welfare and they are unable to reach me by telephone.

_____ If GJB Health Services, LLC has spoken with me by telephone and remains concerned about my welfare but I have refused to go to the emergency room.

_____ If a physical emergency has occurred in the course of my visit to GJB Health Services, LLC office.

_____ _____
Signature Date

Informed Consent to Treatment

1. I acknowledge that I will participate in the development of my treatment plan and authorize GJB Health Services, LLC to provide treatment service(s).

2. I will be provided with specific information about the proposed treatment and service(s), the way the treatment is to be administered and the services are to be provided, alternative treatment modes and services I may pursue and probable consequences of not receiving the proposed treatment.

3. I understand that this Informed Consent is in permanent effect unless it is revoked upon my request.

4. I understand that I may have a copy of this consent if I so request.

5. I understand that I am seeking services within a facility that practices a Treatment Team approach. I understand that this means my provider may seek consultation with his/her GJB colleagues. I am aware that my provider intends to cater the most effective treatment approach for me.

6. I hereby acknowledge that I have been provided with specific, complete, and accurate information concerning the proposed treatment (or services). I have had time to study the information or to seek additional information concerning the proposed treatment or services.

_____ _____

Client Signature Date

GJB Health Services
711 North Lynndale Drive; Suite 1-A
Appleton, WI 54914
gjbhealthservices@gmail.com
Phone: (920) 560-4525 Fax: (920) 560-6618

GJB Health Services

TELEHEALTH CONSENT FORM

Safer at Home Order

Client/Patient Name	
Guardian (if applicable)	
Email Address	
Phone Number	**Alternative phone number**
*** Emergency Contact (Name)**	
Emergency Contact (Phone Number)	

***** I authorize my provider to call my emergency contact person:

- If a crisis occurs
- If my provider fears for my safety and I am unable, or unwilling, to follow directives given to me by the provider

Signature _____

The purpose of this form is to obtain consent for participation in ***telehealth services (Telehealth Services are defined as Zoom Sessions or Phone Sessions)*** for individual, couple or group sessions, in response to the national pandemic of coronavirus (COVID-19). It is GJB Health Services' top priority to protect the health and safety of the community, Support Team, Provider Team, patients and clients.

EXPECTED BENEFITS. Patients/Clients can access psychiatric, neurological, and mental health services during the national pandemic of coronavirus (COVID-19) in cooperation with State of Wisconsin, Governor Tony Evers' ***Safer at Home*** Order and the Centers for Disease Control's recommended healthcare guidelines.

ELECTRONIC COMMUNICATIONS STATEMENT: There is no additional cost to patients/clients to utilize Teletherapy (Zoom or Phone) platforms *from GJB Health Services*. Be aware that any financial balance for user costs such as internet connectivity, devices, or device plans will be the responsibility of each client/patient. Providers will not record sessions nor retain any written transcript of sessions. The same is asked of patients/clients, unless written consent is obtained (Couple's sessions and group sessions may not be recorded).

NATURE OF TELEHEALTH SERVICES. Services involve the use of electronic communications (by Zoom Session or by Phone Session) between healthcare providers and their patients/clients. These sessions will be used for (1) Obtaining psychiatric and psychological history information and/or (2) Conducting individual, couple or group therapy sessions. These sessions will be live and will use interactive video, audio, and/or telecommunication technology.

A. GJB Health Services utilizes ***Zoom.us***. Providers will:
   (1) Create appointments using their professional Zoom accounts and
   (2) Provide clients/patients a link via email to the video appointment

B. Clients/Patients are responsible for:
   (1) Accessing their email to locate links and Meeting IDs for sessions
   (2) Following automatic prompts and provider instructions

POSSIBLE RISKS AND/OR DIFFICULTIES IN TELEHEALTH SERVICES:

Risks include, but may not be limited to:

A. Technology (usually strength of the Wi-Fi connection) may not be adequate to allow for optimal communication (For Example poor resolution of video). If this occurs, the session will be converted to a Telephone Session.

B. In rare instances, security protocols could fail, causing a breach of privacy leading to inadvertent disclosure of personal or medical information. GJB Health Services uses only Zoom Sessions which have long been HIPAA compliant. Zoom has recently updated their safety features to include the requirement of a password which is embedded in the email link and a waiting room feature, which allows the provider to control who has access to session. Nobody can enter a session without the provider admitting them to the session.

C. It is recommended that electronic devices are fully charged, and backup devices are available.

MENTAL HEALTH/MEDICAL INFORMAITON & RECORDS. All existing laws regarding access to medical or mental health information and copies of medical records also apply to telehealth services. Additionally, dissemination of any client/patient-identifiable information for telehealth interaction to researchers or other entities shall not occur without the express written consent of the client/patient.

PAYMENT FOR TELETHERAPY SERVICES. The fees and billing process for telehealth sessions are identical to in-person appointments in our office. It is the responsibility of clients/patients check with their health insurance company to determine if Zoom and Telephone Sessions will be allowed. Some restrictions may apply.

MISSED APPOINTMENT / LATE CANCELATION POLICY. The existing GJB Health Services attendance policy is applicable to teletherapy services. Rescheduling or canceling individual or couple's sessions must be done at least 24 hours prior to the scheduled appointment to avoid incurring a **$150.00 fee**. The fee for late cancellation or no-showing for a group session is **$50.00.**

EMERGENCIES & CRISES: The assessment and evaluation of threats and other emergencies are more difficult for providers to determine during teletherapy. If a life-threatening emergency is experienced, **please call 911 or the suicide prevention hotline (920) 832-4646 / (800) 719-4418 or go to the nearest emergency room. Please call the provider back after emergency services are obtained. If it's outside normal office hours, dial (920) 560-4525 and ask the answering service to patch the call through to Dr. Gerald Bannasch (He will notify the provider of developments).**

IF TELEHEALTH SESSIONS ARE INTERRUPTED BY TECHNOLOGICAL ISSUES. If sessions are interrupted for any reason, such as the technological connection fails, clients/patients should call the provider back immediately. If the provider doesn't receive a call back within 5 minutes, they will attempt to contact the client/patient. If connection cannot be reestablished via phone, and if there is no concern regarding safety for the provider, the Support Team will call within one business day to reschedule the appointment. If safety is a concern, the provider will call the emergency contact person.

CONFIDENTIALITIY. Reasonable and appropriate efforts are made to eliminate any confidentiality risks associated with telehealth services. All existing confidentiality protections under Federal and Wisconsin State Laws apply to information disclosed during telehealth services. Teletherapy takes place outside the traditional therapy setting and the potential for outsiders to overhear sessions is possible if patients/clients are not in private settings.

PRIVACY: It is essential that patients/clients utilize private settings for sessions and eliminate interruptions, where possible.

- Please be sure to protect the privacy of sessions on cellphone or other devices via passwords and encrypted internet connection.

RIGHTS. The client/patient may withhold or withdraw consent to telehealth services at any time without affecting their right to future care or treatment and without risking the loss or withdrawal of any program benefits to which they would otherwise be entitled.

DISPUTES. The client/patient agrees that any dispute arising from the telehealth services will be resolved in Wisconsin, and that Wisconsin State Laws shall apply to all disputes.

I understand and agree with the following points:

1. I understand that my healthcare provider wishes me to engage in a telehealth services during the national pandemic. It is understood that sessions will not be recorded without my pre-approved written authorization. I agree to not record sessions without the specific permission of my provider. Recording of group or couple's sessions is not allowed.

2. I understand that I will not be in the same room as my health care provider during the telehealth session.

3. I understand there are potential risks due to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider, or I, can discontinue telehealth service if it is believed that the telehealth method is not adequate/appropriate for the situation.

4. I understand that reasonable steps will be taken to prevent technology disruptions and disruptions due to disturbances in the home of the provider. I will take precautions regarding disruptions at my location.

5. In an emergent situation, I understand that it is the responsibility of my provider to contact appropriate community support (emergency contact person, 911, ambulance, etc.) if it is believed that I am a clear and present danger to myself (or to someone else), and I am unwilling, or unable, to comply with directives given by my provider.

6. I understand that my provider's responsibility will conclude upon the termination of the video or telephone session.

7. I understand that Zoom Sessions and Phone Sessions fees are the same cost as their corresponding regular sessions would be in GJB Health Services' office.

8. I agree to contact the GJB Health Services' main office, at (920) 560-4525, immediately after my session to pay for the session (including any co-payments, co-insurance payments and/or estimated deductible payments).

9. **I understand that for individual or couple telehealth sessions, the regular rate of $150.00 will continue to apply if I fail to keep my appointment, or if I cancel my appointment with less than 24 hours' notice. For group sessions, the fee is $50.00.**

The following apply only to Virtual Group Sessions:

10. I agree to notify my provider 24 hours in advance if I am unable to keep my appointment for a group session. If I fail to show up for the group session, or cancel with less than 24 hours' notice, I agree to pay $50.00.

11. To avoid disrupting the group process, I will make every effort to be on time. After the first session, if I am more than 5 minutes late in entering the group session, I understand that the group leader(s) reserve(s) the right to not admit me to the group session. I will be charged the $50.00 late fee for the session. We cannot bill your insurance for a session that you do not attend.

12. I understand that group members will not be allowed to exchange identifying information, including the use of last names, to avoid unwanted, or inappropriate, contact between group members. Attempting to contact another group member will be grounds for disallowing my continued participation in the virtual group sessions.

13. I will not record Group Sessions and agree to hold in strictest confidence what is discussed in sessions.

By signing this form, I certify:

- I agree for myself or my child to participate in telehealth services. Children aged 14 and older must also sign this form.
- I have read this form and fully understand its contents including the risks and benefits of participation in telehealth. If I have any questions, I understand that I can call the main office and my questions will be answered to my satisfaction.
- As restrictions change, there may be other alternatives which may be available; I will be notified when this occurs.

_____ _____

Client/Patient (Children 14 or older must sign) Date

_____ _____

Parent/Guardian Date

Please save, or print, pages 2 - 5 and keep them with you for reference

Current Medications

Medication Name	Start Date	Dosage	Frequency	Time Taken

Allergies & any additional details that GJB Health Services, LLC should know.

Allergy	Reaction

Primary Care Physician (Please list as much that is known).

Facility Name _____

Address _____ City _____ St_____ Zip _____

Phone (_____) _____ Fax (_____) _____

Preferred Pharmacy (Please list as much that is known ☺ - We can verify phones / faxes if need be).

Pharmacy Name _____

Address _____ City _____ St_____ Zip _____

Phone (_____) _____ Fax (_____) _____

Preferred Facility / Hospital (In case of needed procedures)

Facility Name _____

Address _____ City _____ St_____ Zip _____

Phone (_____) _____ Fax (_____) _____

GJB HEALTH SERVICES, LLC: AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:	Phone:	DOB:

	❑ EXCHANGE INFORMATION	
	❑ SENDER ❑ RECIPIENT	❑ SENDER ❑ RECIPIENT
Facility Name	GJB Health Services, LLC	
Practitioner(s)		
Address	711 N Lynndale Dr., Suite 1A Appleton, WI 54914	
Phone	(920) 560 – 4525	
Fax	(920) 560 - 6618	

PURPOSE FOR NEED OF DISCLOSURE:

❑ Attorney ❑ Doctor / Practitioner ❑ Insurance ❑ Personal

INFORMATION TO BE RELEASED:

For the Following Date(s): From: _____ To _____ (If left blank, the last year of information will be disclosed.)

❑ All Medical Records ❑ Doctor / Progress Notes ❑ Alcohol &/or Other Drug Abuse Treatment ❑ Final Treatment Summary

❑ Psychiatric Evaluation ❑ Therapy Progress Notes ❑ History & Physical Exam ❑ Other Specify:

❑ Intake Assessment ❑ Psychological Reports ❑ Medication List

PATIENT AUTHORIZATION

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted illnesses, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. Please <u>EXCLUDE</u> the following information from the records released:

❑ Mental Health ❑ Alcohol and/or Drug Abuse ❑ Developmental Disabilities ❑ HIV Test Results

*I understand that any disclosure made is about by Part 2 of Title 42 of the Code of Federal Regulations (Final Rule) governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may disclose it only in connection with their official duties.

CLIENT RIGHTS

I understand that authorizing the disclosure of this health information is voluntary and I am under no obligation to sign this form and that the covered entity may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. (However, provision of research-related treatment or treatment that is for the sole purpose of creating health information for disclosure to a third party will not be provided without your written authorization.) I understand that I may inspect or receive a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy standards. I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request. I understand that I have a right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my writing and present my written revocation to Health Information Department. I understand that if I have questions about disclosure of my health information, I can contact the Health Information Management Department at (920) 391-4700.

* If I fail to specify an expiration date, event, or condition, this authorization will expire in **ONE YEAR** or _____.

_____ _____

Client Signature / Parent / Guardian / Authorized Representative Date

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.

IF YOU HAVE QUESTIONS, PLEASE LET US KNOW.

Introduction

This **Notice of Privacy Practices** is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA).

At GJB Health Services, LLC we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Privacy Practices describes the personal health information we collect and how we use or disclose that information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

Acknowledgement of Receipt of this Notice

You will be asked to provide a signed acknowledgement of receipt of this notice. Our intent is to make you aware of this possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditions upon your signed acknowledgement. If you decline to provide a signed acknowledgment, we will continue to provide you treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

Understanding Your Health Record / Information

Each time you visit GJB Health Services, LLC a record of your visit is made. Typically, this record contains your symptoms, diagnosis, treatment, and plan for future care of treatment. This information, is often referred to as your health or medical records, and serves as a:

- Basis for planning your care / treatment
- Means of communication among the many health professionals who contribute to your care (Referring physician for example)
- Legal document describing that was received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A source of information for public health officials charged with improving the health of this state and the nation
- A source of data of our planning / marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- Better comprehend who, what, where, and why others may access your health information
- Make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of GJB Health Services, LLC, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Privacy Practices upon request
- Inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- Request to amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

GJB Health Services, LLC is required to:

1. Maintain the privacy of your health information
2. Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
3. Abide by the terms of this notice
4. Notify you if we are unable to agree to a requested restriction
5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative location
6. Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law

GJB Health Services, LLC reserves the right to change our Privacy Information practices and to make the new provisions effective for all protected health information we maintain. Revised notices will be available to you at this office during business hours, or by mail if requested. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Examples of How GJB Health Services, LLC May Use or Disclose Your Health Information

Treatment: GJB Health Services, LLC, may use your health information to provide you with medical treatment or services. For example, information obtained by a healthcare provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to those actions.

Payment: GJB Health Services, LLC, may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

Health Care Operations: For example, Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Appointments: GJB Health Services, LLC, may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

Business associates: Some services provided in our organization are provided through Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, or a copy service, which we may use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification, or Communication with Family Members: Health professionals, using their best judgment, may use, or disclose information to notify or assist in notifying family relatives, personal representatives, close personal friends, or other people you identify; information relevant to that persons' involvement in your care or payment information related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: We may contact you to provide appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Required by Law: GJB Health Services, LLC, may use and disclose information about you as required by law. For example, **GJB Health Services, LLC, may disclose information for the following purposes:**

- for judicial and administrative proceedings pursuant to legal authority
- to report information related to victims of abuse, neglect or domestic violence
- to assist law enforcement officials in their law enforcement duties

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Health and Safety: Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions: Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

For more information or to report a problem, or if you have questions and would like additional information, you may contact our practice's Privacy Official, Gloria Bannasch, LPC.

GJB Health Services, LLC
711 N Lynndale Dr., Ste. 1A
Appleton, Wisconsin 54914
920-560-4525

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights -U.S. Department of Health and Human
200 Independence Avenue, S.W. Room 509F, HHH Building
Washington, D.C. 20201
{Services 866-OCR-PRIV (866-627-7748) or 886-788-4989 TTY **}**

I acknowledge that I received/read the Notice of Privacy Practices for GJB Health Services, LLC:

_____
Name of Patient (PRINT)

_____ _____
Signature of Patient (or Authorized Representative) **Date**

Outside Office Hours

Our Privacy Practices and Client Responsibilities are available upon request.

- Office Hours: M – F
- 9:00a – 5:00p (Later depending on practitioner)
    - Appointments are on a "first come, first serve" basis with priority given to clients in emergent need.
- Phone (920) 560-4525
- Crisis Center (920) 436 – 8888

Thank you and Welcome to GJB Health Services, LLC.
*** Change is Hard; You Don't have to do it Alone. ***

For Couples Seeing Gloria Bannasch:

While Gloria Bannasch took training in the Gottman Method of couples therapy, please know that Gloria and GJB Health Services is completely independent in providing clinical services and that Gloria alone is fully responsible for those services. The Gottman Institute or its agents have no responsibility for the services received here.

GJB Health Services
711 N. Lynndale Dr.
Suite 1A
Appleton, WI 54914
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New No Show/Late Cancellation Fee Agreement

I, _____, understand that by signing this form, I agree to call within 24 hours to cancel or reschedule my appointment, otherwise I will be charged **$150.00** for the missed appointment. This no show/late cancellation fee agreement applies to appointments for all GJB Health Services providers, including EEGs scheduled to be completed at this location.

_____ _____

Signature of Client Date