Patient Registration for GJB Health Services, LLC and GJB EEG Services, SC

Today's Date _____

Identification (Name as it appears on Card)

Last Name _____

First Name _____

First name used _____

Middle Name, suffix _____

Previous Name _____

Preferred Name _____

Preferred Pronouns: _____She/Her/Hers

_____He/Him/His

_____They/Them/Their

Date of Birth _____

Social Security Number _____

Emergency Contact

Primary Emergency Contact

Name _____

Relationship to Patient _____

Mobile Phone Number (__ __ __) __ __ __-__ __ __ __

Home Phone Number (__ __ __) __ __ __-__ __ __ __

Work Phone Number (__ __ __) __ __ __-__ __ __ __

Email Address _____

Secondary Emergency Contact

Name _____

Relationship to Patient _____

Mobile Phone Number (__ __ __) __ __ __-__ __ __ __

Home Phone Number (__ __ __) __ __ __-__ __ __ __

Work Phone Number (__ __ __) __ __ __-__ __ __ __

Contact

Primary Phone # (__ __ __) __ __ __-__ __ __ __

Primary # is Circle One: Mobile Land line

Secondary Phone # (__ __ __) __ __ __-__ __ __ __

Work Phone # (__ __ __) __ __ __-__ __ __ __

Client/Patient Email _____

Address _____

_____

_____

_____

I give permission For GJB Health Services, LLC or GJB EEG Services, SC to contact my emergency contact person in the following circumstances: (Please initial where applicable)

_____ If I fail to appear for a scheduled appointment, the practice is unable to reach me by telephone and there is reason to be concerned about my welfare.

_____ 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 during my visit to the practice.

Family/Partner Contact Permission – Primary Contact

I give permission for GJB Health Services, LLC and/or GJB EEG Services, S.C. to initiate contact with, and/or accept communication from, the family member(s) or partner listed below. The type(s) of information that may be discussed/disclosed for each family member or partner has been indicated by checking the appropriate box(es) to the left of each option. If no boxes are selected, no information can be disclosed.

- ☐ 1. Scheduling (appointment management including cancellation and rescheduling)
- ☐ 2. Billing inquiry and payment questions (including balance owed or paid by insurance and/or private payments)
- ☐ 3. Medication management (prescription refills and instructions)
- ☐ 4. Procedures and preparations for appointments
- ☐ 5. Treatment Progress

Name _____

Relationship to Patient _____

Mobile Phone Number **(__ __ __) __ __ __-__ __ __ __**

Home Phone Number **(__ __ __) __ __ __-__ __ __ __**

Work Phone Number **(__ __ __) __ __ __-__ __ __ __**

Email Address _____

Secondary Family/Partner Contact

- ☐ 1. Scheduling (appointment management including cancellation and rescheduling)
- ☐ 2. Billing inquiry and payment questions (including balance owed or paid by insurance and/or private payments)
- ☐ 3. Medication management (prescription refills and instructions)
- ☐ 4. Procedures and preparations for appointments
- ☐ 5. Treatment Progress

Name _____

Relationship to Patient _____

Mobile Phone Number **(__ __ __) __ __ __-__ __ __ __**

Home Phone Number **(__ __ __) __ __ __-__ __ __ __**

Work Phone Number **(__ __ __) __ __ __-__ __ __ __**

Email Address _____

Signature_____ **Today's Date**_____

Driver's License Number and State of Issue

Number_____ State_____

Signature _____ **Today's Date _____**

Demographics

Primary Language: English Spanish Other - Specify _____

Race: Caucasian _____ Asian _____ African American _____ Other____ Or Decline to answer _____

Ethnicity: _____ or Decline to Answer _____

Marital Status Single _____ Married _____ Divorced _____ Widowed _____

Primary Care Doctor

Primary Care Physician _____

Office Number (__ __ __) __ __ __-__ __ __ __

Name of Doctor's Practice _____

Employment

Name of Company _____

Company Phone Number (__ __ __) __ __ __-__ __ __ __

Occupation _____

Preferred Pharmacy

Name of Pharmacy _____

Location (Street) _____

(City) _____

Phone Number (__ __ __) __ __ __-__ __ __ __

Preferred Imaging Facility/Hospital

Name of Facility _____

Location (Street) _____

(City) _____

Phone Number (__ __ __) __ __ __-__ __ __ __

Billing Information

Guarantor (*Responsible for Payment of Charges*)

Guarantor (Will Receive Statements)

Patient's Relationship to Guarantor Self_____ Partner_____ Parent_____ Child _____

If the patient's relationship to Guarantor is "self", skip to the "Insurance" Section.

Guarantor's Date of Birth __ __/__ __/__ __ __ __

Guarantor's Mailing Address House/Apartment # _____

Street _____

City _____ State _____ Zip Code _____

Guarantor's Mobile Phone Number **(__ __ __) __ __ __-__ __ __ __**

Guarantor's Home Phone Number **(__ __ __) __ __ __-__ __ __ __**

Guarantor Email Address _____

Guarantor Social Security Number **__ __ __-__ __-__ __ __ __**

Insurances

Primary Insurance (***Company Name)*** **_____**

Name of Policy Holder ***Enter the name <u>exactly</u> as it appears on the insurance card***

Last Name _____ First Name_____ Middle Name_____

Is Patient the policy holder? Yes _____ No _____

Patient's Relationship to Policy Holder Self ____ Partner ____ Parent _____ Child _____

Policy Holder Birthday _____

Effective Date _____

Expiration Date _____

Member ID Number _____

Name of Group _____

Group Number _____

Policy Type _____HMO _____PPO _____Medicaid _____Medicaid Replacement

_____ Medicare _____Medicare Replacement _____Other

Address of Insurance Company Street _____

Suite/Building _____

City _____

State_____ Zip code _____

Company Phone Number **(__ __ __) __ __ __-__ __ __ __**

Secondary Insurance (***Company Name)*** **_____**

Name of Policy Holder ***Enter the name <u>exactly</u> as it appears on the insurance card***

Last Name _____ First Name_____ Middle Name_____

Is Patient the policy holder? Yes _____ No _____

Patient's Relationship to Policy Holder Self _____ Partner _____ Parent _____ Child _____

Policy Holder Birthday _____

Effective Date _____

Expiration Date _____

Member ID Number _____

Name of Group _____

Group Number _____

Policy Type HMO _____ PPO _____ Medicaid _____ Medicaid Replacement _____

Medicare _____ Medicare Replacement _____ Other _____

Address of Insurance Company Street _____

Suite/Building _____

City _____

State_____ Zip code _____

Insurance Payment Assignment & Release For Primary and Secondary Insurance

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).

Signature_____ **Today's Date_____**

Payment for Services Rendered

- 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, cash or via the patient portal.
- An estimated payment amount is the required payment at the time of service.
- Estimated payments are based on early reimbursement schedules, previously received Explanation of Benefits (EOBs) from insurance companies or services rendered.
- 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 declines payment
- Payments may be made via the Patient Portal, by calling the office at (920) 560-4525
- Statements will be received from Athena Health Care

Signature _____ **Today's Date_____**

Couple's Costs (Not Covered by Insurance) – *For Couples Therapy Only*

- The cost for couples completing The Gottman Love Lab Experience is $212.50 per couple and will be due by the second session. Couples should call the office at (920) 560-4525 between 9:00-12:00 or 1:00-5:00, Monday – Friday to make payment.

- Couples who wish to use the Gottman Relationship Builder may do so for a fee of $250.00 (half the rate of purchasing the Gottman Relationship Coach). This is an optional service and may be purchased at any point during therapy.

- The Art and Science of Love Workshop for Couples is recommended for all couples during therapy. Rates for the in-person workshop is $850.00.

Signature _____ **Today's Date_____**

Informed Consent to Treatment

1. I acknowledge that I will participate in the development of my treatment plan and authorize GJB Health Services 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).

Signature _____ **Today's Date_____**

Telehealth Consent Form

The purpose of this form is to obtain consent for participation in telehealth services (Telehealth Services are defined as Video Sessions or Telephone 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.

I authorize my provider to call my emergency contact person.

Please initial below:

_____ 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

EXPECTED BENEFITS. Patients/Clients can access psychiatric, neurological, and mental health services during the national pandemic of coronavirus (COVID-19).

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.

If Telehealth Sessions are Interrupted by Technology Issues

If sessions are interrupted for any reason, such as the technological connection fails, it is the client/patient's responsibility to contact the therapist immediately (or if appointment occurs within normal business hours (9:00-5:00 Monday – Friday), the client should call the office at (920) 560-4525. If contact cannot be reestablished, the office should be contacted at the beginning of the next business day to reschedule. If safety is a concern, the provider will call the emergency contact person.

GJB Health Services, LLC utilizes *Zoom.us, Athenahealth, and Gottman Connect for video sessions and assessment. Epion interfaces with Athenahealth for the purpose of pre-visit check in.*

Providers will:

1. Create appointments using the appropriate video conferencing platform
2. Provide clients/patients a link via email to the video appointment

Clients/Patients are responsible for:

1. Accessing their emails to locate links and Meeting IDs for sessions
2. Following automatic prompts and provider instructions
3. Being on the call at the appointed time

Possible Risks and/or Difficulties in Telehealth Services

Risks include, but may not be limited to:

1. 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.
2. 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 HIPAA compliant video services. Videos are conducted via Athenahealth, Zoom or Gottman Connect.
3. It is recommended that electronic devices are fully charged, and backup devices are available.

Signature_____ **Today's Date**_____

Mental Health / Medical Information & 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.

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.

Signature _____ **Today's Date_____**

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 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 Video Sessions and Phone Sessions fees are the same as their corresponding regular sessions would be in my provider's 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. If I cancel my appointment with less than 24 hours' notice, I understand that for individual or couple's telehealth sessions, the regular rate of $150.00 will continue to apply if I fail to keep my appointment. For group sessions, the late cancellation/no show fee is $50.00.

Signature_____ **Today's Date_____**

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 questions will be answered to my satisfaction.
- As restrictions change, other alternatives may become available. I will be notified when/if this occurs.

_____ **Today's Date_____**

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

_____ **Today's Date_____**

Parent/Guardian

Current Medications (Feel free to attach a written or typed list)

Medication Name	Start Date	Dosage	Frequency	Time Taken

Allergies and Additional Details

Allergy	Reaction

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 the 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:

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

The practice 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/GJB EEG Services, S.C. May Use or Disclose Your Health Information

Treatment: The practice 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: The practice 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. 9 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.

For Couples who receive Gottman Method Counseling: Gloria Bannasch is a Certified Gottman Therapist and Jillian Rotzenberg is a Level 2 Trained Gottman Method Therapist; however, GJB Health Services is completely independent of The Gottman Institute. The Gottman Institute or its agents have no responsibility for services received at GJB Health Services; our Provider Team is fully responsible for those services.

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, NCC, BC-TMH, CGT
GJB Health Services, LLC
711 N Lynndale Drive; Suite 1A
Appleton, Wisconsin 54914
Phone: (920) 560-4525 - Fax: (920) 560-6618

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 Resources
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/GJB EEG Services, SC:

_____	_____	_____
Name of Client/Patient (PRINT)	**Signature of Client/Patient (or Authorized Representative)**	**Date**

Office Hours and Support Team Availability:

Our front office is open Monday – Friday from 9:00AM-12:00 and from 1:00-5:00PM
We are closed from 12:00PM to 1:00PM for the lunch hour.

When staff is unavailable and outside of office hours, voice mails may be left on our confidential voicemail. Your call will be returned as soon as possible. Please do not leave credit card information on the voicemail system. Phone (920) 560-4525.

If there is an emergent need, inside or outside of office hours, please go to the nearest emergency room or contact your primary care physician. The phone number for the Crisis Center in Appleton is: (920) 436 – 8888.

Appointment Scheduling Policy:

Appointments are on a "first come, first serve" basis with priority given to clients in emergent need. Each member of the Provider team sees clients/patients according to the schedule that works best for them. The Support Team Members can schedule appointments for all providers.

COVID-19 Procedures:

Clients continue to be seen virtually (as of July 4, 2021); however, some providers are seeing clients in the office. Currently, we continue to follow CDC Guidelines for medical offices, thus masks must be worn at all times for the duration of your visit. We do require that our clients and patients be vaccinated for COVID-19 (for at least 14 days), prior to in office sessions; a negative rapid COVID-19 test (taken within 24 hours) will also be acceptable. No guests or children may attend appointments with clients/patients unless they will be in the session with you and are needed for provision of care.

GJB Health Services, LLC and GJB EEG Services, SC

No-Show or Late Cancellation Fee Agreement

I understand that by signing this form, I agree to notify the practice at least 24 business hours prior to my scheduled appointment if I need to cancel or reschedule my appointment. If I fail to provide at least 24 business hours' notice that I will be unable to keep my appointment, I understand that I will be charged **$150.00** for the missed appointment. This fee is not insurance billable.

This no show/late cancellation fee agreement applies to appointments for all Providers and includes EEGs and Neuropsychological Testing scheduled to be completed at this location. This agreement applies to all clients/patients except those whose treatment is covered by Medicaid, Badger Care or Medicaid replacement insurance. For the clients/patients who are so covered, the Practice reserves the right to discharge clients/patients after the first late cancelled or no-show appointment.

_____	_____	_____
Name of Client/Patient (PRINT)	**Signature of Client/Patient (or Authorized Representative)**	**Date**

Our email and voicemail systems both contain time signatures.

Contact Information:

Phone: (920) 560-4525 **Email:** gjbhealthservices@gmail.com **Fax:** (920) 560-6618
Website: https://www.gjbhealthservices.com

Zero Tolerance Policy

Our Team Members believe in treating everyone with respect and dignity. To maintain a calm, pleasant, and safe environment for all, we do not yell, raise our voices, make demands, or use foul language when interacting with one another, clients/patients, their families, or representatives. We expect, and insist, upon being treated in an equally respectful manner.

Mistakes and misunderstandings happen and can be upsetting. Our Team Members will listen, validate concerns, and offer solutions. Disrespectful treatment from patients/clients, their family members, or representatives will not be tolerated. Yelling or raised voices, threatening behavior, threatening language, accusations, threats, and/or cursing, are all considered to be inappropriate and disrespectful behavior.

When confronted with problematic behavior, Team Members have been authorized by the owner to issue one reminder to speak respectfully, and in an appropriate tone. Failure to follow directives from Team Members in such situations will result in termination of the phone call, or directing the individual who is non-compliant to leave the property. These egregious behaviors and/or language are also considered to be sufficient grounds for the immediate discharge of the patient/client from all services.

Our Team appreciates all cooperation with our Zero Tolerance Policy. As always, if you have any questions or concerns, you can call our office directly and speak with any one of our Team Members at (920) 560-4525.

I acknowledge that I have received, read, and understood the Zero Tolerance Policy for
GJB Health Services, LLC and/or GJB EEG Services, SC

_____	_____
Name of Client/Patient (PRINT)	Date

_____
Client/Patient's Authorized Representative (PRINT)

GJB Health Services
GJB EEG Services

711 North Lynndale Drive; Suite 1A
Appleton, WI 54914
Phone: (920) 560-4525
Fax: (920) 560-6618

Medical Records Release of Information Form

Patient/Client Name: _____

Parent/Guardian: _____

Address Street: _____ Apartment/House Number: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Date of Birth: _____

I authorize (GJB Provider) _____ and/or GJB Health Services/GJB EEG Services, to release my medical records or other healthcare information (unless specified to be excluded), including intake forms, chart notes, reports, correspondence, billing statements, and other written or verbal information concerning my health and treatment to be sent to or received from the following person and/or company/health care facility:

Other: _____

Excluded: _____

Address Provider/Facility: _____

Street: _____ Suite: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

For Couple's Therapy Clients: I understand that my partner must also sign this release before any information can be released for any reason.

Partner Two Signature: ***Date:*** _____

This authorization will be considered valid until GJB Health Services/GJB EEG Services receives notice, written or verbally, that it has been revoked. I understand that the practice will notify me when my health information is released to another outside provider. If my GJB provider would like to release information to another provider, I will be asked to sign a separate Release of Information form specifically for that purpose.

To be completed *only* by a GJB Health Services or GJB EEG Services Team Member:

Format of Release: Mail (*Certified:* Yes No) Paper Flash Drive Faxed Picked up by _____

Signature of Person picking up information

Date of Release: _____ **Completed by Team Member**: _____