Aspire
Behavioral Health Services

Intake Packet 1

What you will need:

- O Complete the Insurance Verification Form
- O Complete the release of Information Form
- O Complete the Email Agreement Form
- O A copy of all Health and/or Medicaid Insurance cards (front and back)
- O A copy of the most recent Diagnostic Evaluation Report

Please complete these items and return them to the clinic one on of the following ways:

- setting up a time to drop them at our office: 1202 Broadway N. Menomonie, WI.
- scan and email them back: stoeklent@jjclp.org
- Fax them to: (715) 231-1817

Insurance Verification of Eligibility and Benefits

Please complete each section to the best of your ability**,** and we will contact your insurance company to verify your coverage.

Client Name:	
Parent/Caregiver Name:	
Phone:	
Email:	
Address:	
Date of Birth of potential client:	
Diagnosis Code (found on diagnostic report):	
Diagnosis Description:	
Primary Insurance Co:	
Primary Insurance Co. Phone #:	
Subscriber's Name:	
Subscriber's Date of Birth:	
Member ID:	
Policy #:	
Group #:	
Secondary Insurance Co.:	

AUTHORIZATION:

I certify that I am covered by _____ Insurance Company and hereby authorize a designee of Aspire Behavioral Health Services to release all information necessary to secure the payment of benefits.

Signature:_____

Date: _____

EMAIL AGREEMENT

Client/Caregiver Name:

_____

Date of Birth:

_____

Client E-mail Address:_____

- The Jesse James Center for Learning and Play, LLC and Aspire Behavioral Health Services cannot guarantee the security and confidentiality of an e-mail transmission. Please be aware, if your e-mail is a family address, other family members may see your messages. Because of the many internet and e-mail factors beyond our control, we cannot be responsible for misaddressed, misdelivered or interrupted e-mail. The Jesse James Center for Learning and Play, LLC and Aspire Behavioral Health Services is not liable for breaches of confidentiality caused by yourself or a third party.
- The Jesse James Center for Learning and Play, LLC and Aspire Behavioral Health Services will attempt to read and respond promptly to e-mail but cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Time sensitive issues should be addressed by telephone.
- Please do not use e-mail for communications regarding sensitive health information, such as sexually transmitted diseases, AIDS/HIV, mental health or substance abuse.
- All e-mails between you and Aspire Behavioral Health Services regarding diagnosis or treatment will be made part of your treatment record.
- The Jesse James Center for Learning and Play, LLC and Aspire Behavioral Health Services may forward your e-mail to other staff members as necessary for response. However, your e-mail will not be forwarded outside the The Jesse James Center for Learning and Play, LLC and Aspire Behavioral Health Services team without your authorization.
- You are responsible for protecting your password or other means of access to e-mail.

Signature of Client/Guardian: _____

Date: _____

Printed Name of Client/Guardian: _____

Tanya Stoeklen, CEO of Clinical Operations_____ Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name:	**DOB:**
Street Address:	**City/State/Zip:**
Phone:	**Email:**

I understand this release is voluntary and applies to all programs and services operated under the auspices of **Aspire Behavioral Health Services and Jesse James Center for Learning and Play LLC**. I understand that my *personal identifiable information* (PII) may be protected by the federal rules for privacy under the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and/or other applicable state or federal laws and regulations. I understand that my PII may be subject to re-disclosure by the recipient without specific written consent of the person to whom it pertains, or as otherwise permitted. I also understand that the recipient may not condition treatment, payment, enrollment or eligibility on whether I sign this form, except for certain eligibility or enrollment determinations. **I understand that I may revoke this authorization at any time by notifying Aspire Behavioral Health Services in writing but if I do, it will not have any effect on any actions taken before receipt of the revocation.**

I hereby authorize Aspire Behavioral Health Services to:

☐ **Exchange with** ☐ **Release to** ☐ **Obtain information**

☐ **Verbally only** ☐ **In written form only** ☐ **Both verbally and in writing**

Organization or Individual receiving or communicating the information (check all that apply & list names):

☐ School(s):

_____

☐ Service Coordinator(s)/Case Manager(s):

_____

☐Physicians:_____

☐ Insurance Company:

_____

☐ Other Therapy Providers:

_____

☐ Daycare/respite providers:

_____

☐ Other:

_____

Description of information to be exchanged/released/obtained:

☐	Medical Records	☐	Evaluation Reports
☐	Program Assessments	☐	Psychological Exam
☐	Discharge Summary	☐	Case Histories
☐	Educational Records	☐	Progress Reports

☐ Clinical Records (behavior analytic, psychological, physical, occupational & speech therapies)

☐ Other: _____

☐ Any of the above

This information is to be used by Aspire Behavioral Health Services for the following purpose(s):

☐ Development of applied behavior analysis (ABA) assessment(s) and/or treatment services

☐ Other: _____

Duration of release (check one):

☐ This release will remain in effect for two (2) years, unless otherwise stipulated or revoked in writing.

☐ From (MM/DD/YY) _____ To (MM/DD/YY) _____

_____ _____

Signature of Client or Legally Authorized Representative **Date**

Print Name and relationship of Legally Authorized Representative to student/consumer/client