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

Gloria J. Bannasch, M.Ed, LPC, NCC, DCC, BCC
Dr. Gerald J. Bannasch, MD
Kathleen Mueske, LPC
Tania Hanford, MS, LPC
Tricia Gonzalez, LPC

New Client Registration

Please print legibly.

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

SSN _________-_________-___________ Email ____
** Required for Medicare / Medicaid Plans please :)*

Insurance Information

Insurance Company ____

Member # ____ Group # __________________________

Primary Policy Holder's Name _________________________________ Primary's DOB ________________

Primary's Employer (the Group) ____

Relationship to Client Self Spouse Parent Other ____

Insurance Company's Provider Services Phone Number ____

Insurance Company's Address ____

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).

_____________________________________ _______________________

Signature Date

Financial Responsibility Form

Client Name ______________________________ Date of Birth ____________________

Responsible Party (if different than Client) ____

Responsible Party's Address ______________________ City __________ State ___ Zip__________

Credit Policy

Fees for services are your responsibility. As a service to you, we bill your insurance (provided that your company will accept claims from us if we are not in their provider network). It is your responsibility to verify your coverage and to obtain prior authorization if your coverage requires it. **Any amount not covered under your insurance is your responsibility. We request that all clients pay at the time of service to satisfy deductibles, coinsurance, copays, or any private payments.** This applies to all clients, whether new or established. If you are unable to clear your balance within 30 days or pay at least 50%, please contact our office to discuss a payment plan. A late payment fee of 1.5% monthly may be assessed. We urge you to notify us if you have a temporary financial problem to help us avoid other methods of collection.

- I agree that GJB Health Services may contact me regarding balances I may owe in the form of written statements or the contact number associated with my account.
- I understand that GJB Health Services has the right to pass remaining balances dated beyond 90 days to affiliates such as collection agents. These affiliates of GJB Health Services may contact me via the phone number associated with my account, if such an event arises.

Any fees for legal testimony or reports that may be requested of us due to our involvement in your case will be billed directly to you because insurance will not cover these services. The cost is $150.00 for each report and $100.00 per conversation with court representatives. You will be notified in advance if you will be responsible for any of these additional charges.

- We reserve the right to bill patients **$150.00 for any sessions that you miss or cancel without giving us 48 hours' notice.**
- Patients **must send payment when balances acquire over $100.00** prior to scheduling another appointment with any GJB Health Services provider. In this case, patients are responsible to:
  - Contact the office and make payment over the phone via credit card
  - Send payment via check in the mail
- Telephone consultations lasting **over 20 minutes** will also be billed directly to you as insurance will not compensate us for these types of services.
- Client accounts will be changed to "In-Active Status" who have not been seen within 6 months.
- In the event that hospitalization is necessary, GJB Health Services will not be able to provide treatment during your hospital stay. If you are hospitalized, treatment will be provided by the psychiatrist or other physician of your choice or that your plan covers.

I, the undersigned, agree to abide by the above stated financial policies.

______________________________ ______________

Client 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 an 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 I have the right to withdraw this Informed Consent at any time, in writing.

4. I understand that this Informed Consent is in effect for a 15-month period of time.

5. I have been advised that I may have a copy of this consent if I so request.

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

Current Medications

Medication Name	Dosage	Frequency	Time Taken

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

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 ___________

The following page is intended for **Dr. Gerald Bannasch's patients only. It refers to the Release of Information intended for your Primary Care Physician.*

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

Name:	PHONE:	DOB:

	❑ **EXCHANGE INFORMATION**	
	✓ **SENDER** ❑ **RECIPIENT**	❑ **SENDER** ✓ **RECIPIENT**
Facility Name	GJB Health Services, LLC	
Practitioner(s)	❑ Gloria Bannasch, M.Ed., LPC, NCC, BCC, DCC ✓ Dr. Gerald Bannasch ❑ Tania Hanford, LPC ❑ Kathleen Mueske, LPC	Primary Care Doctor: _______________________________
Address	2323 W Everett St 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

In compliance with Wisconsin Status, which require special permission to release otherwise privileged information, this Authorization applies to mental health, alcohol and/or drug abuse, developmental disabilities, and HIV test result information, UNLESS EXCLUDED BELOW:

❑ 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 expired 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 (HIPPA).

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, diagnoses, 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 yoru 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 access 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 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 health care 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 healthcare 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 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.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant

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 work force 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.

GJB Health Services, LLC
2323 West Everett Street
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 have received 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 – 7:00p (Depending on practitioner)
  - Appointments are on a "first come, first serve" basis with priority given to clients in emergent need.
- Phone (920) 425 - 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 has taken 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.

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