# **Informed Consent to Treatment**

I authorize to determine the form of treatment necessary and agree to participate in the development and advancement of my treatment plan.

Once you have reviewed the relevant issues with your counselor, please sign below to indicate that you have obtained all information that you deem necessary and that you accept the policy and procedures outlined above. A copy of this form is available to you upon request.

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Client Signature Date Parent/Guardian Date

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Agency Witness Date

Parent/Guardian signature is required if the client is under 18 years of age.

Information about Professional services, Practices, Policies, and Patient's Bill of Rights

This is an outpatient counseling facility that provides individual therapy. Confidentiality is maintained in all services provided in accordance with Federal Regulations. Individuals are given information about professional services, practices, policies and patient's bill of rights for their reference. Your length of treatment will vary depending on the nature of the problems that bring you here for services, the pace that we work at during sessions, as well as your motivation and the resources available to you to get well. Each individual has a right to terminate treatment at anytime and for any reason. I am currently accepting new patients.

## **CANCELLATION AND NO SHOW POLICY:**

A full session fee will be charged for all appointments cancelled with less than 24 hours notice. Because insurance does not pay for missed sessions, you will be billed for missed sessions if you are using insurance to pay for therapy. This policy is in effect unless we determine that you were not able to make your appointment or give sufficient notice due to circumstances beyond your control.

No shows will be charged and billed to you at your regular session rate. Because counseling sessions are in high demand and waiting lists for appointments are long, and if there happens to be 2 consecutive appointment cancelations in a row your treatment will be terminated and a list of referral counselors will be provided for you.

## **FEES:**

You are expected to pay our agreed-upon fee or your insurance deductible/co-payment by cash, check or credit card at the time of each session, unless other arrangements have been made. Credit card payment will incur a $2.00 service charge at time of processing. The fees may be raised on a yearly basis, and that will be discussed with you prior to rate increase. If you use your health insurance to help pay for your sessions, you are responsible for verifying and understanding the limits of your coverage, as well as any co-payments and deductibles. You are responsible for all service fees not covered by health insurance, all deductibles and co-payments. If, during the course of treatment, your insurance ceases to cover your sessions, you have the option of paying out-of-pocket to continue treatment with us. Counseling services will be placed on hold for any bills exceeding $300.00. Counseling services will resume upon payment of outstanding bill. We also offer a reduced fee scale that offers a reduced rate for therapy services based on income. Documentation of income must be provided to determine if you qualify for reduced rate sessions.

Initial Consultation. Minutes

Individual Counseling: Minutes

## **CONTACTING ME:**

If I am not immediately available by telephone. Calls are usually returned within 24 hours during normal business time, with the exception of weekends and holidays. If you are unable to reach me and feel that you can't wait for me to return your call, contact your primary care physician, psychiatrist or the nearest emergency room and ask for the behavioral health clinician on call. You may also contact Milwaukee County after hours crisis line at (414) 257-7222

## **MINORS:**

If you are under the age of 18, please be aware that the law provides your parents/guardians with the right to examine your treatment records with a proper written request. Parents are also allowed to be involved in treatment, such as but not limited to informational phone calls and attendance at sessions. Minors over the age of 14 have additional rights, such as but not limited to the right to withdraw from therapy without parental consent. It is our policy to have a parent/guardian present during the entire session time for minors under the age of 16; there will be no minors dropped off and picked up for sessions due to liability reasons.

## **BENEFITS, RISKS AND ALTERNATIVES TO COUNSELING:**

**Benefits of Counseling:** Improved well being, better relationships, solutions to specific problems, a better understanding of oneself and reduced or elimination of symptoms

**Alternatives to Counseling:** Medications, no services, inpatient treatment, and alternative holistic practices.

**Possible consequences of not receiving proper counseling:** Continuation of current problems, addressing unpleasant aspects of your life, you may experience uncomfortable feelings and painful emotions and symptoms and/or an exacerbation of problems and symptoms. When you receive services for Mental Health, Alcoholism, Drug Abuse, or Developmental Disability as an inpatient or outpatient, you have the following rights under Wis. Statute Sec. HFS 75 and HFS 6.

## **TREATMENT AND RELATED RIGHTS:**

You have the right to be free from having unreasonable arbitrary decisions made about you, to receive prompt adequate treatment that is effective, to be informed and educated about your treatment as it relates to session duration, frequency of session and therapeutic procedures, to refuse any treatment, including medications, to refuse or to give informed consent to participate in drastic treatment or in experimental research, to a humane psychological and physical environment.

## **COMMUNICATION AND PRIVACY RIGHTS:**

It is my ethical obligation to safeguard information we obtain about you in the course of our work together, within the limits of, or exceptions to confidentiality as law determines it. You have the right to refuse to be filmed or taped without your consent to have your conversation with staff and all medical and health care records kept confidential in accordance with WI law, Sec.51.30, Stats. To have your records released at your discretion with a properly signed and completed release of information. And to see your health care records after termination of treatment with proper notice. By law records are kept for 7 years after termination of therapy services. After 7 years the records are destroyed. If utilizing insurance to cover the cost of counseling services please be advised that most insurance carriers require disclosure of diagnosis, date of treatment and treatment plan goals in order to pay for services rendered. Be aware that a diagnosis becomes part of your permanent medical record. Please consult with your insurance carrier for more information about what is required. Additionally, to provide quality care there will be times when colleagues will be consulted for continuity of care-you will always be made privy to case consultations that occur.

## **COUNSELOR CREDENTIALS:**

All counselors at this facility are licensed by the State of Wisconsin and hold an advanced degree in the specialty area of Social work, Counseling or Psychology. Continuing education is a top priority so all providers attend classes, seminars, conference and the like on a regular basis. Additionally, all providers are active members of various professional organizations in their field. There are no providers on staff that prescribe medications. If medications are recommended a referral will be made to the appropriate provider of your choice.

# **Mind Body Program Policies**

Psychological Services Evaluation 10 minutes [First Appointment] $350

Treatment Sessions 10 minutes $300

**MISSED APPOINTMENTS WITHOUT 24 HOUR NOTICE $300**

Fee Payments: You are ultimately responsible for payment if payment is not received from your insurance company for any reason. Understand that you are ultimately responsible for any balance not paid by insurance.

All deductibles and copays must be paid at the time of service by check or credit card.

All clients will receive a statement billing them for any outstanding fees still dues on their account. All payments are due within 30 days of the statement. If after 30 days you fail to make payment in full or contact the office to make arrangements, your account will be turned over to collection. Should your account result in collective action, you will be responsible for collecting fees, including: court costs, attorney fees, and/or collection agency fees.

ADDITIONAL PRORATED BILLING WILL BE MADE FOR THOSE AREAS OF TIME AND SERVICES:

Calls made to your provider outside of your session, preparation of reports or forms, and consultation with collateral personnel lie physicians, therapists, case workers, attorneys, other agency service providers]

LIMITATION OF PRIVACY: By signing this for you are authorizing the release of all information required to act on insurance claims and permit a photographic or other facsimilie reproduction of this authorization to be used in place of the original. You hereby give consent to Mind Body Program to release medical information pertaining to your care/claim to any insurance company. You understand that identifying information will be disclosed to Bayshore Billing and your insurance company for the purpose of processing claims and requesting authorization of treatment and to a collection ageney to recover fees should collective action occur.

I HAVE READ THE ABOVE POLICY AND FULLY UNDERSTAND AND AGREE TO COMPLY WITH IT.

Signature Date
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