PLATTEVILLE FAMILY RESOURCE CENTER, INC.

Admission, Consent to Treatment, Fees Agreement

Name: _____ Birthdate: _____

The above named client or the parent(s) or guardian(s) on the client's behalf and this facility agrees that the center will admit and provide care, active treatment or evaluation services specified for the client, commencing with the date of admission or execution of this agreement, whichever is later, until the date of discharge.

AUTHORIZATION FOR CARE AND TREATMENT

I, the client, or the parent(s) or guardian(s) of the client, agree to:

1. Active treatment services
2. Usual and customary psychological treatment for common acute and chronic psychological disorders such as anxiety, mood, and trauma related, and disruptive behavior and other conditions listed in the DSM-5.

Prior to beginning procedures that are intrusive and carry risk, I, the client or the parent(s) or guardian(s), will be informed of the procedure, benefits sought, possible alternative procedures and common foreseen risks. I understand I will be asked to give written consent for some specific procedures. The procedures include:

1. EMDR
2. Use of restrictive or aversive behavioral techniques

RIGHT TO A SECOND OPINION

The client has a right to a second psychological opinion when counseling is recommended.

CLIENT RIGHTS

I, the client or parent(s) or guardian(s), have been advised of the client's rights under state and federal law and I have been advised how to file a complaint about violation of these rights.

CLIENT BEHAVIOR AND RESPONSIBILITIES

Policies and rules for clients are posted in the reception area and a copy has been handed out with this agreement. Additional copies are available upon request.

Clients are expected to participate in the treatment program, as identified in their individual treatment plan. Rules and guidelines regarding their responsibilities are incorporated in the overall treatment, copies of which can be provided for the client or parent(s) or guardian(s).

PATIENTS RIGHTS/CONSENT

Platteville Family Resource Center, Inc., (in accordance with HSS-94 Patient Rights Statues) wants you to continue to be aware of your rights as a patient and asks for your informed consent to receive therapy.

A BILL OF RIGHTS poster appears in the waiting area.

The following is some general information about the therapy process:

A. The benefits of therapy are to help alleviate the problems and symptoms you present.
B. Therapy is conducted in sessions between therapist and client talking about the problems presented.
C. If there are any expected side effects from therapy or medication (if applicable) they will be discussed with you.
D. The therapist will suggest alternative treatment modes and make referrals when appropriate or necessary.
E. The possible consequences of not receiving therapy can be discussed.
F. Informed consent is given for each twelve consecutive months during therapy.
G. You have the right to withdraw informed consent in writing at any time.
H. You have the right to file a grievance under HSS-94 if you believe your patient rights have been unjustly violated or terminated by Community Counseling Center staff.
I. The approximate duration and desired outcome of treatment shall be agreed upon in the treatment plan.
J. Therapists have a right to discharge clients involuntarily from treatment for abusive language and/or behavior toward staff.

DUTY TO REPORT

A. Therapists in this facility are mandatory reporters (in accordance with WI Stat. – 49.141) in regard to abuse reported by victims under the age of 18.
B. Therapists in this facility have a duty to warn (in accordance with WI Stat. – 51) in regard to danger to self or another.

CONFIDENTIALITY

All clients at this facility have the right to confidentiality. Treatment records will be released only upon receiving consent of as the law allows or requires.

The facility cooperates in several educational programs. I, the client or parent(s) or guardian(s), am advised that university or college students involved in educational programs affiliated with

the facility may shadow, participate, and attend staffing of the client and review client treatment records. The facility will instruct these students about maintaining confidentiality of this information. Students may, under staff, supervision, also assist in providing treatment. Students will sign a confidentiality agreement.

RIGHTS/GRIEVANCE/CONFIDENTIALITY INFORMATION ACKNOWLEDGEMENT

I ACKNOWLEDGE THAT:

1. I have received a copy of the following policies and procedures:
    a. Confidentiality policy, P-20467
    b. Rights of Patients and Residents and the Grievance Procedure, P-20377

ENFORCEABILITY OF AGREEMENT

The client, the parent/guardian, and the Platteville Family Resource Center, Inc. agree to the terms of this agreement. Should any part of this agreement become unenforceable due to changes in the law or to judicial interpretation of the law, the remaining portion of this agreement will remain enforceable and valid.

The client or parent/guardian may withdraw consent to this agreement at any time.

Completion of this form is voluntary. If not completed, a staff person will sign as a witness that you received the information and understood items 3 and 4. This information is filled with the patient's record and only authorized individuals have access to it.

I read and received the foregoing and received a copy of this agreement along with the following attachments:

1. Your Right and the Grievance Resolution Process
2. Client's Rights Under Federal Law and DHS 134
3. Fee Information
4. Confidential Information Release Authorization

I ACKNOWLEDGE THAT:

1. I have been given the opportunity to ask questions I may have regarding policies.
2. I understand that all services will be provided on an outpatient basis and that no written or verbal information will be released without my consent as indicated on a signed Release of Information form except in certain situations required by law. I have been informed of these exceptions.
3. I understand that all treatment requires my consent and/or consent of my guardian.

Fee Information

Fee Information: A session normally lasts **45-60** minutes. Fees vary according to therapists: Masters Level: $240.00 per hour Ph.D. Level: $270.00 per hour.

Insurance & Billing Information: It is YOUR responsibility to contact your insurance carrier to determine if your insurance will cover outpatient psychotherapy and/or psychological services and to what limits this coverage extends.

Platteville Family Resource Center will file patient claims as a service to you.

We do not accept responsibility for collecting your insurance claim or negotiating disputes. Assuming your insurance company will "take care of the bill" is not wise.

Payments by insurance companies vary widely. Insurance payments rarely meet what the therapists charge, and you are responsible for the balance. Patients are billed monthly. Should your account be turned over to our collection agency, you will be responsible for their collection fee in addition to the amount due to Platteville Family Resource Center, Inc.

Preauthorization: Many insurance companies require preauthorization for services. Patients are responsible for notifying the clinic if such preauthorization is necessary. We will do whatever paperwork is needed to obtain preauthorization, **but failure to notify Platteville Family Resource Center of the need for preauthorization will make you liable for any charges your insurance company refuses to cover.**

Cash Clients: Fees are payable on the date of service.

Cancellation Policy: When it is necessary to cancel an appointment, 24 hour notice is required, except in the case of an illness or emergency. Patients will be charged a Master's Level: $100 fee and Ph.D. Level: $120 fee for improperly canceled or missed appointments. Unlike a physician or dentist's office, only one patient can be scheduled at a time for counseling.

I hereby agree to be directly responsible to The Platteville Family Resource Center for charges incurred, and I acknowledge that I fully understand the above and will comply with clinic policy.

X _____ X _____

Responsible Party, Date Witness, Date

By my signature below, I acknowledge that this agreement was reviewed and approved for this client.

SIGNATURE	**NAME-PRINTED**	**DATE SIGNED**
X _____ Parent or Guardian		
X _____ Client, if presumed competent		
X _____ Therapist		