Name _____

Date of Birth _____

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Adult Consent for Mental Health Treatment

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health evaluation and/or treatment by professional clinical staff from Family Service. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
   a. The benefits of the proposed treatment
   b. Alternative treatment modes and services
   c. The manner in which treatment will be administered
   d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
   e. Probable consequences of not receiving treatment

   The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Wisconsin Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Therapy.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing and psychotherapy, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. I am aware of this agency's fees which are also available for my review upon request.

4. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential record at Family Service and I consent to disclosure for use by Family Service staff for the purpose of continuity of my care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. **Discharge Policy:** There are circumstances under which I may be involuntarily discharged. I have read and understand the discharge policy of the clinic.

6. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

7. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

8. **If you believe you have been treated differently because of race, color, national origin, religion, sexual orientation, disability or age, you may file a discrimination complaint with the following agencies:**

Office for Civil Rights
Office of Justice Programs
U.S. Department of Justice
810 Seventh Street NW
Washington, DC 20531

Wisconsin Department of Justice
Office of Crime Victims Services
P.O. Box 7951
Madison, WI 53707-7951

Wisconsin Department of Justice
Contract Compliance Office
P.O. Box 7857
Madison, WI 53707-7857

I have read and understand the above, have had an opportunity to ask questions about this information and I consent to an evaluation and outpatient mental health treatment through the clinic based upon an assessment that determined appropriateness of outpatient treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider at any time about the above information or the treatment I am receiving.

_____ _____

Signature of client ages 18 years or older or legal representative **Date**

☐ By checking this box, I hereby verify that this electronically produced signature is the actual signature of the client, parent or legal guardian who has legal authority to provide such consent.

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101 W. Broadway, 2nd Floor
Waukesha, WI 53186
262 547-9967

2021/2022 Demographic Information for United Way

In order to receive certain funding to create better programs which support our community, we are asked to provide the United Way with demographic information of all clients we serve.
The information is reported as compiled information.
Your name and birth date will never be used in the reports.
Thank you for your participation in our efforts to better serve the community.

Please fill out the following information. Place an 'X' next to the appropriate response.

Your gender:	☐ Female	☐ Male	☐ Transgender	☐ Other

What is your annual household income?

$0.00 - $9,999	☐
$10,000 - $14,999	☐
$15,000 - $24,999	☐
$25,000 - $36,999	☐
37,000 – 49,999	☐
$50,000 - $74,999	☐
More than $75,000	☐

What Zip code do you live in?

Are you or have you ever been a member of the Armed Forces?	☐ **Yes**	☐ **No**

How do you Describe Yourself? (Check One)

Racial Background:	
African American/Black	☐
Asian	☐
Caucasian/White	☐
Middle Eastern	☐
Multi-Racial	☐
Native American	☐
Native Hawaiian/Pacific Islander	☐
Other	☐
Ethnicity:	
Hispanic/Latino	☐
Non- Hispanic/Latino	☐

Your Age:	
12-17	☐
18-24	☐
25-34	☐
35-44	☐
45-54	☐
55-64	☐
65-74	☐
75-84	☐
85-94	☐
95 & older	☐

What is the primary language spoken in the Home?

☐ **English**	☐ **Hmong**	☐ **Spanish**	☐ **Other**

Client Fee & Insurance Form

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Client's Information

Today's Date: _____

First Name: _____ Last Name: _____

Parent/Guardian Name: _____ Social Security #: _____

Date of Birth: _____ Age: _____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Prefer not to say ☐ Other _____

Address: _____ Apartment #: _____

City, State & Zip Code: _____

Check box if you do not want a telephone confirmation call. ☐ No

Cell phone #: _____ Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Cohabitating

Employer's Name: _____ Phone #: _____

Address: _____ Suite #: _____

City, State & Zip Code: _____

Responsible Party's Information

First & last name: _____

Relationship to client: _____

Phone #: _____ Work phone #: _____

Insurance Information

Primary Insurance Company's Name: _____

Address: _____

Subscriber ID #: _____ Group #: _____

Phone Number: _____

Policy holder's name: (If different than client's) _____ Date of Birth: _____

Relationship to client: _____ Phone #: (if different than client's) _____

Secondary Insurance Company's Name: _____

Address: _____

Subscriber ID #: _____ Group #: _____

Phone Number: _____

Policy holder's name: (If different than client's) _____

Relationship to client: _____ Phone #: (if different than client's) _____

Fee Information

Counseling sessions are 38-52 minutes. Insurance contracts may vary. Payment is due at each session.

Initial Evaluation:	Master Level Therapist: $145.00	♦	Ph.D. Psychologist: $185.00
Psychotherapy Session:	Master Level Therapist: $130.00	♦	Ph.D. Psychologist: $170.00
Psychological Testing:	$230.00/hour		
School Observation:	$135.00/hour		
Group Therapy:	$60.00/hour – Also, see designated program's fee schedule.		

24-hour cancellation notice is required.

Late Cancellation Fee:	$25.00	No Show Fee:	$25.00
Fee for copying a file:	$25.00	Fee for Letters:	$25.00

Family Service accepts private health insurance payments. Our therapists are preferred providers in several health care networks. Because insurance plans vary, we are unable to guarantee insurance coverage for services. If you are not clear about your benefits, please contact your insurance company. You are responsible to pay deductibles or co-payment fees as required by your insurance plan. You will receive a monthly statement of your account.

CLIENT AUTHORIZATION FOR RELEASE OF INFORMATION & ASSIGNMENTS OF BENEFITS

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

I request that payment of authorized benefits be made on my behalf to Family Service. I assign the benefits payable to which I am entitled, including Medicare, Medical Assistance (Medicaid), private health insurance, and other health plans.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for the co-pay, deductibles, and for all charges, whether or not paid by said insurance.

I agree to the assignments and financial responsibility for the services rendered to me according to Family Service's customary fees as described.

_____ _____

Signature of Client **Date**

☐ By checking this box, I hereby verify that this electronically produced signature is the actual signature of the client, parent or legal guardian who has legal authority to provide such consent.

_____ _____

Signature of Parent or guardian, if client is under the age of 18 **Date**

Updated 8/29/19

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Acknowledgment of Receipt
For the Notice of Privacy Practices
Regarding Health Information

Client Name: _____

Date of Admission: _____

By signing this form, you acknowledge that Family Service has given you a copy of its Notice of Privacy Practices Regarding Health Information, which explains how your health information will be handled in various situations. All clients receiving services on or after April 14, 2003 will be asked to sign this form.

By my signature below, I acknowledge I have received a copy of the Family Service Notice of Privacy Practices Regarding Health Information and have been given an opportunity to discuss my concerns and questions.

_____ _____

Client Signature **Date**

_____ _____

Parent or guardian signature, if client is under the age of 18. **Date**

☐ By checking this box, I hereby verify that this electronically produced signature is the actual signature of the client, parent or legal guardian who has legal authority to provide such consent.

10/9/2017

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CONSENT FOR TELEHEALTH OR TELEPHONE MENTAL HEALTH SERVICES

By signing this form, I understand and agree with the following:

1. Telehealth is the delivery of services using interactive technologies (audio, video, or other electronic communication) between a practitioner and a client/patient who are not in the same physical location.

2. The interactive technologies used in Telehealth services incorporate network and software security protocols to protect the confidentiality of client/patient information transmitted via any electronic channel.

3. The laws that protect the privacy and confidentiality of health, mental health and other services also apply to telehealth sessions and tele-intervention. Information obtained during a telehealth session or meeting that identifies me or my child will not be given to anyone outside of Family Service without my consent except what is necessary for necessary for establishing my care, maintaining treatment records, performing billing, securing payment, and performing other administrative healthcare operations.

4. There are both mandatory and permissive exceptions to confidentiality, including, but not limited to, the reporting of child, elder, and dependent adult abuse, expressed threats of violence toward an ascertainable victim; and/or expressed threats of suicide or threat of other serious forms of self-harm.

5. Any electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

6. The exchange of information will not be direct and any paperwork exchanged will likely be provided through electronic means or through postal delivery following HIPAA compliance laws.

7. I understand that Family Service will take all necessary precautions to protect my privacy and confidentiality but I also understand that there is a slight risk of a security breach with any internet-based communication. However, I believe that the potential benefits of telehealth outweigh this risk.

8. I understand, agree and accept responsibility for protecting my personal safety and the confidentiality of my Telehealth sessions by placing myself in a safe, private, comfortable environment for my telehealth sessions, free from distractions and sufficiently distant from others who are not explicitly invited into in my Telehealth sessions.

9. I agree to participate in Telehealth services only when I am using a secure internet connection.

10. I understand that my email address is required for audio-visual services, and I will keep Family Service informed of any change to my email address.

11. I understand that I have the right to withhold or withdraw my consent to the use of telehealth at any time. Withdrawing my consent will not affect my eligibility to receive future services.

12. This service is provided by various technology platforms (including but not limited to video, phone, and email) and may not involve direct face-to-face communication. I acknowledge that there are benefits and limitations to this type of service.

13. My practitioner and I will regularly reassess the appropriateness of continuing my service delivery through the use of the technologies we have agreed upon today and my practitioner will suggest modification or change to the service delivery plan as needed.

14. I acknowledge that appointment confirmations, appointment changes or other important communications with Family Service will be conducted through the telephone. I agree to check my telephone voicemail regularly. I further understand that all Telehealth invitations for my sessions will come through the email address I provided to Family Service and telehealth sessions will take place using a HIPAA compliant **Zoom Healthcare** and/or HIPAA compliant **Microsoft Teams** platform.

15. I have read and understand the information provided above regarding telehealth, and all of my questions have been answered to my satisfaction.

I hereby consent to the use of Telehealth by Family Service.

Name of Client: _____

Name of Parent/Guardian: _____

Client/Parent/Guardian Signature: _____

Date: _____

☐ By checking this box, I hereby verify that this electronically produced signature is the actual signature of the client, parent or legal guardian who has legal authority to provide such consent.