

Name: _____
Date of Birth: _____

**Consent for Evaluation - Treatment Child/Adolescent**

1. **Consent to Evaluate/Treat:** I voluntarily consent that my child will participate in a mental health evaluation and/or treatment by professional clinical staff of 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 licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Wisconsin Law for Psychological, Social Work, Professional Counseling, or Marriage and Family Counseling.
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 my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my child's 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 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 have been informed of the agency's fees which are available to me for review upon request.
4. **Confidentiality, Harm, and Inquiry:** Information from my child's 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 child's care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if my child is deemed to present a danger to himself/herself 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 my child 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 of my child 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 the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.**

\_\_\_\_\_  
 Signature of minor age 14 years or older

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of legal representative for minor

\_\_\_\_\_  
 Date

By checking this box, I am verifying this electronic produced signature verifies the actual signature of the person named here.



# family service

counseling • support • compassion

101 W. Broadway, 2<sup>nd</sup> Floor  
 Waukesha, WI 53186  
 262 547-5567

## 2021/2022 Child 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.**

### What is your annual household income where your child resides?

\$0.00 - \$9,999	<input type="checkbox"/>
\$10,000 - \$14,999	<input type="checkbox"/>
\$15,000 - \$24,999	<input type="checkbox"/>
\$25,000 - \$36,999	<input type="checkbox"/>
37,000 – 49,999	<input type="checkbox"/>
\$50,000 - \$74,999	<input type="checkbox"/>
More than \$75,000	<input type="checkbox"/>

### Child's Gender?

Female	<input type="checkbox"/>
Male	<input type="checkbox"/>
Transgender	<input type="checkbox"/>
Other	<input type="checkbox"/>

### How do you describe your child? (Check One)

<b>Racial Background:</b>	
African American/Black	<input type="checkbox"/>
Asian	<input type="checkbox"/>
Caucasian/White	<input type="checkbox"/>
Middle Eastern	<input type="checkbox"/>
Multi-racial	<input type="checkbox"/>
Native American	<input type="checkbox"/>
Native Hawaiian/Pacific Islander	<input type="checkbox"/>
Other	<input type="checkbox"/>
<b>Ethnicity:</b>	
Hispanic/Latino	<input type="checkbox"/>
Non- Hispanic/Latino	<input type="checkbox"/>

### What is your child's age?

0-3	<input type="checkbox"/>
4-5	<input type="checkbox"/>
6-11	<input type="checkbox"/>
12-17	<input type="checkbox"/>
18-24	<input type="checkbox"/>

What is the zip code where the child resides: \_\_\_\_\_

### What is the primary language spoken in the Home?

<input type="checkbox"/> English	<input type="checkbox"/> Hmong	<input type="checkbox"/> Spanish	<input type="checkbox"/> Other
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# Client Fee & Insurance Form



## 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  Cohabiting

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**



## **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.



## 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.