Western Wisconsin Health
1100 Bergslien St. Baldwin, WI 54002
715-684-1510 (Fax) 715-684-1524

General Informed Consent

I, the undersigned, acknowledge that the following has been explained to me and my questions satisfactorily answered:

1. Costs of therapy, insurance coverage, co-payments, private pay options and no show policy.
2. Availability of supervising psychologist.
3. Client's rights explained regarding confidentiality, access to records, and the following:
   a. The benefits of the proposed treatment of services; b. The way the treatment is to be administered and the services;
   c. The expected treatment side effects or risks of side effects which are a reasonable possibility;
   d. Alternative treatment modes and services;
   e. The probable consequences of not receiving the proposed treatment and services
4. The informed consent is effective for 12 months from the time consent is given. The right to with draw the informed consent can be done in writing at any time.
5. Grievance policy and procedure
6. Emergency arrangements
7. Written copy of above received

_____ _____

Consumer Date Parent/Guardian Date

Fee Agreement: In order to accommodate the needs and request of our clients, Western Wisconsin Health file to various insurance companies and has enrolled in various managed care insurance programs. While we are pleased to be able to provide these services to you we will make every effort to work with your managed care, utilization review and/or insurance company, but clients are always financially responsible for services rendered. The fee for initial intake session is $306.00 for Doctoral and Master's level therapist. Ongoing psychotherapy costs are $239.00 per 60 minute session for Ph.D/Psy.D's and Masters level therapist. Ongoing psychotherapy costs are $127.00 per 30 minute session costs are $164.00 per 50 minute session. Other costs or arrangements will be explained by your therapist. For example, if your therapist needs to appear in court, write reports, or perform other duties not covered by insurance. **A No Show Fee of $50.00 will be assessed in the event that a 24 hour cancellation notice is not received, unless there is an emergency.** If for any reason that you would encounter any type of court proceedings your insurance would not cover these fees. The fees for court are $300.00 an hour for Doctoral level therapist and $225.00 for a Masters level therapist. Consumers participating in Medicare/Medicaid insurance programs will only be charged Baldwin Area Medical Center's customary fees. Medicare/Medicaid patients will not be responsible for any additional costs after the insurance is billed. Due to litigious divorce/custody situations, the clinic has been put in the position of insisting on all payments due be made at the time of service for all clients under the age of 18. Western Wisconsin Health will not split fees between parties. It is up to the parties involved to address whatever the divorce decree mandates, not the clinic. Therefore, all accounts need to be kept current. This means all co-payments, co-insurance or deductibles are to be paid at each session by the parent who brings the child to the session. If your child comes in by themselves all co-payments, co-insurance or deductibles must still be paid.

Assignment of Benefits: I hereby authorize payment of benefits to Western Wisconsin Health for services rendered to myself and/or dependents. I further understand that ultimately I am financially responsible for services rendered if the insurer denies reimbursement and am responsible for any deductibles, or coinsurance requirements.

_____ _____

Consumer Date Parent/Guardian Date

I understand that my mental health records are protected by Federal and State laws. A copy of this authorization will be treated in the same manner as an original.

Notice of Privacy Practices: Your signature below indicates that you have received the agreement and agree to its terms and also services as an acknowledgement that you have received the HIPPA Notice Form described in the brochure. I understand that consent can be revoked or revised at any time in writing.

_____ _____

Consumer Date Parent/Guardian Date

Records Release: I hereby authorize Western Wisconsin Health to release information, if requested, to my insurance company, it's managed care companies and other regulatory agencies, as determined by the Executive Director, on behalf of myself and/or dependents.

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Consumer Date Parent/Guardian Date