INFORMED CONSENT TO TREATMENT INFORMATION

Welcome to WLCFS Christian Family Counseling (CFC). Thank you for choosing CFC to assist you. We pray that the matters you bring are resolved to the glory of our loving Lord.

CFC, a ministry of WLCFS-Christian Family Solutions (founded in 1965), is a Christian counseling service with offices in Wisconsin and Minnesota. CFC is committed to providing Christ-centered healing and helping services.

It is our prayer that your relationship with your Christian therapist will help you and/or your family members to gain better insight into your daily living and to grow toward a healthier, more satisfying Christian life. This requires mutual effort by both you and your therapist. Change does not happen by itself; we would fail without the strength of our gracious Lord. Living the Christian life is both a joy and a challenge for all of us.

The following is important information about our services and your treatment. Please read it carefully and feel free to ask questions about anything that is not understandable. You will be asked to sign a Client Acknowledgment Form, indicating that you understand and agree with the terms of this Informed Consent.

THE PROCESS OF THERAPY

Depending on the personalities of the client and therapist and the particular problems that the client brings, psychotherapy may vary. There are different approaches to address different problems. The currently acceptable treatment modes to help you with your specific situation will be discussed with you. Be assured that the specific approach agreed upon to help you will be a God-pleasing one. Unlike medical care, psychotherapy requires an active effort on your part. Together with the therapist, you will choose how to approach your concerns. To be successful you will have to work toward goals both during sessions and at home.

Psychotherapy has both benefits and risks. Psychotherapy has been shown to reduce feelings of distress, create better relationships, and resolve specific problems. Risks include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger, loneliness, and helplessness that may be part of the process of change. Relationships may also be affected. Side effects or risks of side effects from any psychotropic medications should be discussed with your physician. Conversely, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Your experience may be similar to or vary from those described above.

There are two main steps in psychotherapy. The first step is assessment. You and your therapist will spend time evaluating your needs and your goals and gathering pertinent information. A treatment plan will be completed and will include an initial assessment, diagnosis (as appropriate), your treatment goals, and intervention techniques to accomplish these goals. You will then need to make a decision to continue the therapy process. If

you choose not to work with your therapist, your therapist will refer you to another mental health professional in your area. Therapy involves a commitment of time, energy, and money, and any questions you have about the process should be discussed whenever they arise. Should you choose to not pursue therapy or discontinue prematurely against your therapist's advice, your symptoms may return and/or worsen.

The second step is the actual therapy. While the first step usually takes 1 to 2 sessions, the actual number of sessions needed to accomplish goals for clients will vary. Some matters are quite complex, and considerable time is needed to accomplish the goals. Other situations take less time to resolve. Your therapist will make every effort to be as time and cost efficient as possible to help you resolve your concerns.

SCHEDULING APPOINTMENTS

CFC business hours are generally 8:00 a.m. to 4:30 p.m. Monday through Friday. Please call during these hours especially when you are making or changing appointments, have questions regarding your bill, insurance, etc.

Psychotherapy sessions typically can last 15 minutes up to an hour. The first session may last up to 1½ hours for the initial assessment. If there are other people joining you in a session, the session may also last longer. A session usually occurs once per week to begin with and then, as progress toward your goal for therapy is being made, the time between your sessions is spread out. In cases of a mental health emergency or "after hours" coverage, please call the office and follow the voicemail prompt to be connected with a professional counselor immediately. For life-threatening situations, please call 911 or go to your nearest hospital.

Due to the nature of therapy, your commitment to the therapy process is important and includes keeping your scheduled appointments. Our cancellation policy requires a **24-hour notice** of any cancellations (except for emergencies or other circumstances beyond your control). **If such notice is not given, you may be charged $75 for a missed appointment.**

CONFIDENTIALITY

The therapy relationship is confidential. Your therapist cannot release any information about the therapy process without your written permission. This includes even the fact that you are a client here. Confidentiality is governed by Federal and State law, and CFC will abide by the law. A copy of our Privacy Practice Notice is available on our website at www.ChristianFamilySolutions.org. You may also request a written copy of this notice.

However, confidentiality does have its legal and ethical limitations. A therapist may break confidentiality if, in his/her judgment, it is necessary to protect the safety or welfare of the client or another person. If you threaten to hurt yourself or someone else, or raise suspicion of child abuse, or if a minor under the age of 16 reports sexual activity, your therapist is bound by law to report it to the proper authorities.

Your therapist may discuss your case with other CFC professional staff including contracted consultants for purposes of effectively coordinating treatment and/or to meet state-mandated requirements.

Finally, all state-certified mental health clinics are obligated to maintain clinical records in accordance with the respective administrative rule. CFC maintains an electronic record that is confidential and kept within a secure software system which was developed for use specifically for the counseling industry. All records are not only secure but also have a redundant backup system in the event of a system malfunction. Only authorized personnel have access to these electronic records.

CONSULTATIONS AND SUPERVISION

You or your therapist may request to consult with the agency's supervising psychiatrist and/or psychologist regarding the course of your treatment. Also, as part of your therapist's ongoing professional development, s/he may be receiving supervision. Your therapist will inform you at your first meeting if s/he is being supervised. Any outside-of-clinic assessments or evaluations will be handled according to the policies and procedures of the outside source.

FEES AND INSURANCE

Sessions typically can last 15 minutes up to an hour in length with time allowed for administrative work, e.g., record-keeping and consultations. It is important for you to be prompt for your sessions; the charge will not be reduced if you are late.

The total cost to CFC for each standard session begins at $150. The actual amount is determined by the specific procedure code utilized and your therapist's credentials.

CFC billing is divided into two categories:

1. Non-insured or out-of-pocket services—CFC offers a Prompt Pay Discount to any client that pays at the time of service or within 10 days of service. Please see the **Prompt Pay Discount** policy for applicable rates. While the actual cost of a standard therapy session begins at $150 per hour, voluntary contributions of churches, organizations, and individuals can help pay a portion of the therapy cost that a client cannot realistically afford. A **Sliding Fee Discount** is also available for those that meet certain income and family size levels. An application, income documentation, and approval are required to determine the discount level.

2. Insured services—Your health insurance may cover all or a portion of the fee; however, you (not your insurance company) are responsible for full payment of fees. It is very important that you find out exactly what mental health services your insurance policy covers. We cannot guarantee payment from your insurance company. CFC contracts with many insurance companies to be an in-network provider, which may result in lower costs for you. You are financially responsible for charges not covered by your insurance plan(s) as well as charges in excess of benefits paid under such plans. It is also your responsibility to inform us of changes in your coverage. If you fail to inform us of changes in your insurance coverage, you will be responsible for full payment of fees. By signing the Client Acknowledgement Form, you authorize release of information necessary to process claims incurred by you at Christian Family Counseling. You further authorize direct payment of all medical insurance benefits for services provided to you through Christian Family Counseling.

For your convenience, CFC accepts MasterCard and Visa. You can make a payment online at www.ChristianFamilySolutions.org. You will receive monthly statements that will notify you of any balance on your account. Unless prior arrangements are made, past due balances may be submitted to a third party, such as a collection agency or attorney, for collection. "Past due" is defined as being 30 days delinquent from the date of billing. CFC reserves the right to determine when a past due account is referred to a third party for collection.

Non-payment of fees also can affect your client status at CFC. If you have accrued an outstanding balance of $500 or more, your therapist may taper the frequency of scheduled appointments until you have reduced your

balance to less than that amount. In addition, your therapist may close your case and/or refer you to an alternate provider if your balance persists at this level for durations of 3 months or longer.

CLIENT RIGHTS AND SATISFACTION

If you consider that the services you received are unsatisfactory or think your rights have been violated, you have the right to use a grievance procedure. Please contact any CFC office for an information packet on the procedures to follow. Or you may contact the Clients Rights Specialist to request the packet: Christian Family Counseling, Attn: Clients Rights Specialist, W175 N11120 Stonewood Drive, Germantown, WI 53022. Include your name, address, and phone number. Also, the State of Wisconsin (Statute Section 51.61) and the State of Minnesota (Statute 144.651) have established a Patient Bill of Rights. These rights are posted in our waiting room or are available as a handout.

CLIENT ACKNOWLEDGMENT FORM

Your signature on this form indicates that: 1) You have received this **Informed Consent to Treatment Information** document and you agree to abide by its stated terms regarding the cost/charges for care and treatment services during your professional relationship with your therapist; 2) You have been informed of the **Privacy Practice Notice** available to you on our website or in written form; 3) You consent to enable us to use and disclose your personal health information for purposes of treatment, payment, and health care operations; 4) You have received a brochure describing your rights and the grievance procedure; and 5) You have received the handout describing the Mission Statement and Statement of Beliefs.

The time period for this informed consent shall be one year. At the end of this time frame, this material will be shared with you again and your informed consent obtained. You have the right to withdraw informed consent at any time, in writing. This will, in effect, terminate therapy.

10/23/14

Informed Consent for Telehealth Services

Definition of Telehealth

Telehealth involves the use of electronic communications to enable Christian Family Counseling's mental health professionals to connect with individuals using interactive video and audio communications.

Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. CFC utilizes secure, encrypted audio/video transmission software to deliver telehealth.

4. I understand that if my counselor believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health professional that can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.

5. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to "face-to-face" psychotherapy.

6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.

7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my counselor in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific

details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.

8. I understand that my express consent is required to forward my personally identifiable information to a third party.
9. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.
10. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

Payment for Telehealth Services

Christian Family Counseling will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. In the event that insurance does not cover telehealth, the individual wishes to pay out-of-pocket, or when there is no insurance coverage, a prompt pay discount is available. Information regarding the prompt pay discount is available on our website http://www.christianfamilysolutions.org/counseling/personcounseling-clinics/what-does-it-cost

Patient Consent to the Use of Telehealth

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

I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

_____

Print Name

_____ _____

Client's Signature Date

_____ _____

Parent or Guardian Signature Date

WLCFS Christian Family Solutions
healing. helping.

Mission Statement

The mission of Christian Family Counseling is to provide Christ-centered, Scripture-based counseling services with the purpose of reflecting the healing and helping ministry of Jesus Christ to the people of a sinful and troubled world.

Statement of Beliefs

- We believe in the Triune God, one God eternally existent in three persons: Father, Son, and Holy Spirit (Matt. 28:19).

- We believe that the Bible is the inspired (2 Pet. 1:21), inerrant (1 Cor. 2:13), infallible (Jn. 10:35), and completely authoritative (2 Tim. 3:16) Word of God.

- We believe that all people are sinners by nature and activity (Ps. 51:5) and unable to reconcile themselves to God by any human efforts (Eph. 2:1; Rom. 3:9-18).

- We believe that salvation is by God's grace and action alone (Eph. 2:8-9) accomplished through His Son, Jesus Christ (Jn. 3:16; Acts 4:12; Gal. 4:4-5).

- We believe that Jesus Christ is the eternal Son of God, who became man, lived the perfect life that God requires, died a substitutionary death, and rose again from the dead to atone for the sins of the whole world (Col. 2:9; Acts 2:23-24; 1 Pet. 3:18).

- We believe that it is by the working of the Holy Spirit through the Means of Grace that people receive faith in Jesus as their Lord and Savior (1 Cor. 12:3). The Holy Spirit gives believers the wisdom and strength to walk according to His will (Phil. 2:13; Gal. 5:16-25; Is. 41:10).

- We believe that Jesus shall return visibly and bodily to judge all people. Those who believe in Jesus will live with Him forever, while unbelievers will be condemned to an eternity in hell (Mk. 13:26; Jn. 5:27-29).

manager's decision to the County Agency Director. You must make this appeal within 14 days of the day you receive the program manager's decision. You may ask the program manager to forward your grievance or you may send it yourself.

- The County Agency Director must issue his or her written decision within 30 days after you request this appeal.

State Grievance Examiner

- If your grievance went through the county level of review and you are dissatisfied with the decision, you may appeal it to the State Grievance Examiner.
- If you are paying for your services from a private agency, you may appeal the program manager's decision directly to the State Grievance Examiner.
- You must appeal to the State Grievance Examiner within 14 days of receiving the decision from the previous appeal level. You may ask the program manager to forward your grievance to the State Grievance Examiner or you may send it yourself. The address is: State Grievance Examiner, DHS, P.O. Box 7851, Madison, WI 53707-7851.

Final State Review

Any party has 14 days of receipt of the written decision of the State Grievance Examiner to request a final state review by the Administrator of the Division of Mental Health and Substance Abuse Services (DMHSAS) or designee. Send your request to the DHS Administrator, P.O. Box 7851, Madison, WI 53707-7851.

You may talk with staff or contact your Client Rights Specialist, whose name is shown below, if you would like to file a grievance or learn more about the grievance procedure used by the program from which you are receiving services.

Your Clients Rights Specialist is:
Myles Tonnacliff, Ph.D., LP
W175 N11120 Stonewood Drive
Germantown, WI 53022
800-438-1772

NOTE: There are additional rights within sec. 51.61(1) and DHS 94, Wisconsin Administrative Code. They are not mentioned here because they are more applicable to in-patient and residential treatment facilities. A copy of sec. 51.61, Wis. Stats. and/or DHS 94, Wisconsin Administrative Code is available upon request.

State of Wisconsin
Department of Health Services
Division of Mental Health & Substance Abuse Services
www.dhs.wisconsin.gov
P-23112 (12/2008)

Client Rights and the Grievance Procedure for Community Services*

for Clients Receiving Services in Wisconsin for Mental Illness, Alcohol or Other Drug Abuse, or Developmental Disabilities

*The term Community Services refers to all services provided in non-inpatient and non-residential settings.

Client Rights

When you receive any type of service for mental illness, alcoholism, drug abuse, or a developmental disability, you have the following rights under Wisconsin Statute sec. 51.61 (1) and DHS 94, Wisconsin Administrative Code:

Personal Rights

- You must be treated with dignity and respect, free from any verbal, physical, emotional or sexual abuse.
- You have the right to have staff make fair and reasonable decisions about your treatment and care.
- You may not be treated unfairly because of your race, national origin, sex, age, religion, disability or sexual orientation.
- You may not be made to work except for personal housekeeping chores. If you agree to do other work, you must be paid.
- You may make your own decisions about things like getting married, voting and writing a will, if you are over the age of 18, and have not been found legally incompetent.
- You may use your own money as you choose.
- You may not be filmed, taped or photographed unless you agree to it.

Treatment and Related Rights

- You must be provided prompt and adequate treatment, rehabilitation and educational services appropriate for you.
- You must be allowed to participate in the planning of your treatment and care.
- You must be informed of your treatment and care, including alternatives to and possible side effects of treatment, including medications.
- No treatment or medication may be given to you without your written, informed consent, **unless** it is needed **in an emergency** to prevent serious physical harm to you or others, or **a court orders it.** [If you have a guardian, however, your guardian may consent to treatment and medications on your behalf.]
- You may not be given unnecessary or excessive medication.
- You may not be subject to electro-convulsive therapy or any drastic treatment measures such as psychosurgery or experimental research without your written informed consent.
- You must be informed in writing of any costs of your care and treatment for which you or your relatives may have to pay.
- You must be treated in the least restrictive manner and setting necessary to achieve the purposes of admission to the program, within the limits of available funding.

Record Privacy and Access

Under Wisconsin Statute sec. 51.30 and HFS 92, Wisconsin Administrative Code:

- Your treatment information must be kept private (confidential), unless the law permits disclosure.
- Your records may not be released without your consent, unless the law specifically allows for it.
- You may ask to see your records. You must be shown any records about your physical health or medications. Staff may limit how much you may see of the rest of your treatment records while you are receiving services. You must be informed of the reasons for any such limits. You may challenge those reasons through the grievance process.
- After discharge, you may see your entire treatment record if you ask to do so.
- If you believe something in your records is wrong, you may challenge its accuracy. If staff will not change the part of your record you have challenged, you may file a grievance and/or put your own version in your record.
- A copy of sec. 51.30, Wis. Stats., and/or HFS 92, Wisconsin Administrative Code, is available upon request.

Grievance Procedure & Right of Access to Courts

- Before treatment is begun, the service provider must inform you of your rights and how to use the grievance process. A copy of the Program's Grievance Procedure is available upon request.
- If you feel your rights have been violated, you may file a grievance.
- You may not be threatened or penalized in any way for presenting your concerns informally by talking with staff, or formally by filing a grievance.
- You may, instead of filing a grievance or at the end of the grievance process, or any time during it, choose to take the matter to court to sue for damages or other court relief if you believe your rights have been violated.

Grievance Resolution Stages

Informal Discussion (Optional)

You are encouraged to first talk with staff about any concerns you have. However, you do not have to do this before filing a formal grievance with your service provider.

Grievance Investigation—Formal Inquiry

- If you want to file a grievance, you should do so within 45 days of the time you become aware of the problem. The program manager for good cause may grant an extension beyond the 45-day time limit.
- The program's Client Rights Specialist (CRS) will investigate your grievance and attempt to resolve it.
- Unless the grievance is resolved informally, the CRS will write a report within 30 days from the date you filed the formal grievance. You will get a copy of the report.
- If you and the program manager agree with the CRS's report and recommendations, the recommendations shall be put into effect within an agreed-upon timeframe.
- You may file as many grievances as you want. However, the CRS will usually only work on one at a time. The CRS may ask you to rank them in order of importance.

Program Manager's Decision

If the grievance is not resolved by the CRS's report, the program manager or designee shall prepare a written decision within 10 days of receipt of the CRS's report. You will be given a copy of the decision.

County Level Review

- If you are receiving services from a county agency, or a private agency and a county agency is paying for your services, you may appeal the program

Client Acknowledgment

Your signature on this form indicates that: 1) you have received the Consent to Treatment document and you agree to abide by its stated terms regarding the cost/charges for care and treatment services during your professional relationship with your therapist; 2) you are aware that the Privacy Practice Notice is available on www.ChristianFamilySolutions.org or in writing at your request; 3) you consent to enable us to use and disclose your personal health information for purposes of treatment, payment, and health care operations; 4) you have received a brochure describing your rights and the grievance procedure; 5) you have received the handout describing our Mission Statement and Statement of beliefs; and 6) by supplying your home phone number, mobile phone number, e-mail address, and any other personal contact information, you authorize Christian Family Counseling to employ a third-party automated outreach & messaging system to use your personal information, the name of your therapist, the time and place of your scheduled appointment(s), and other limited information, for the purpose of notifying you of a pending appointment, missed appointment, unpaid balances, or any other reasonable healthcare-related communication.

_____
Print Name

_____ _____
Client's Signature Date

_____ _____
Parent or Guardian Signature Date

_____ _____
Spouse or Other Family Member(s) Present Date

The above information was shared with me again:

_____ _____
Client's Signature Date

_____ _____
Parent or Guardian Signature Date

_____ _____
Spouse or Other Family Member(s) Present Date

For office use only:

Provider: _____ Location: _____