THE PSYCHOLOGY CLINIC, Inc.
Client Information Form

Account Number	Therapist	Date of Service

CLIENT	NAME Last	First	MI	Name I prefer to be called	Spouse/Partner Name

ADDRESS Street	City	State	Zip Code	Home Phone:	Can we call you? --

BIRTHDATE	GENDER	MARITAL STATUS --	Cell Phone:	Can we call you? --

EMPLOYER Company Name	Address	Work Phone:	Can we call you? --

Emergency Contact	Relationship	Address	Phone Number

Family Physician	Clinic	Address	Phone Number

PARENT OR LEGAL GUARDIAN (if applicable)	Relationship to Client	Birth Date	Home Phone

NAME Last First MI	Address	Cell Phone

EMPLOYER	Address	Work Phone

POLICY HOLDER INSURANCE INFORMATION

PRIMARY INSURANCE	Name of Carrier and Subsidiary Agency	Phone Number	Effective Date

Subscriber / Policy Number	Subscriber Name (Last, First, MI)	Birth Date	Relationship to Client

Group Number	

Subscriber's Address if Different	Group Name / Employer

SECONDARY INSURANCE	Name of Carrier and Subsidiary Agency	Phone Number	Effective Date

Subscriber / Policy Number	Subscriber Name (Last, First, MI)	Birth Date	Relationship to Client

Group Number	

Subscriber's Address if Different	Group Name / Employer

(Please Sign and Date other side)

THE PSYCHOLOGY CLINIC, Inc.

The fee for the initial consultation is _____. The fee for subsequent sessions is _____ per unit of services provided. Units are based on the amount of professional time utilized. You will be billed for all the time that is reserved for you. If additional time or services (such as telephone contacts) are provided, a pro-rated fee may be charged. There may be a charge if your insurance company, another agency or a third party requires a report. Failure to provide 24 hours advance notice of appointment cancellation or failure to show for an appointment may result in a charge at the regular fee. Repeated late cancellations or no shows may result in your being discharged from the clinic.

If you have insurance, a claim will be filed with your insurance company. Deductibles and/or co-payments are due at the time of your appointment. If a claim filed with your insurance company is disputed, this office cannot accept responsibility for collecting those fees from your insurance company or for negotiating a settlement. Payment of any unpaid portion of the balance will be expected within 30 days after your insurance company notifies The Psychology Clinic, Inc. of the extent of its liability or payment. Arrangements can be made for monthly payments toward your balance.

It is assumed that this financial relationship will continue as long as services are being provided or until such time as the client notifies The Psychology Clinic, Inc. of a wish to terminate treatment. Once treatment terminates, any balance not paid in full will be considered due. If acceptable financial arrangements have not been made, The Psychology Clinic, Inc. reserves the right to utilize legal means to obtain reimbursement. This may result in releasing names and addresses to a collection agency.

I authorize The Psychology Clinic, Inc. to release any medical information needed to process my insurance claims. I further agree to and authorize payment of any health insurance policy benefits directly to The Psychology Clinic, Inc. I understand that I am financially responsible for services not covered or partially covered by my health insurance. A copy of this authorization shall be as effective and valid as the original.

My signature below indicates that I read, understand and agree to this insurance and fee policy. I will take responsibility for all charges to any account for which I am the designated responsible party.

_____ _____

Client/Legal Representative signature **Date**

THE PSYCHOLOGY CLINIC, Inc.

CONSENT TO RECEIVE TREATMENT

Clients of The Psychology Clinic, Inc. have the right:

To be provided with specific, complete and accurate information about the treatment that is being proposed, which includes:

1. The purposes and expected benefits of the proposed treatment
    - The methods of the proposed treatment
    - The possible side effects of the proposed treatment
    - The alternatives to the proposed treatment
    - The possible consequences of not receiving the proposed treatment
2. If the proposed treatment is to include medication, the possible side effects, instructions for use and precautions of the medications in writing
3. The fees you are expected to pay
4. Under what circumstance we may involuntarily discharge someone for inability to pay or for behavior not reasonably the result of mental health symptoms
5. To participate actively in the development of your treatment plan and to request a second opinion concerning the proposed treatment
6. To review the proposed plan of treatment and recommended duration of treatment regularly
7. To meet with the supervising psychologist of your therapist at any time during treatment
8. To be treated without discrimination because of previous treatment history
9. To refuse medications or other treatment, except in an emergency or if ordered by a court
10. To confidentiality of your treatment records as prescribed by federal and state laws
11. To bring damages against persons violating their rights or confidentiality
12. How to use the grievance process
13. How to access after-hours emergency services
14. To be given a copy of this document
15. To withdraw this consent at any time, in writing

Your signature on this form indicates that you understand your rights and you have access to all your questions about services at The Psychology Clinic, Inc. satisfactorily answered. Your signature also indicates that you have been given access to written copies of your Consent to Receive Treatment form and have been provided written information concerning, and am fully aware of, the clinic's Policies and Practices to Protect the Privacy of Health Information and the clinic's Client Bill of Rights and Grievance Policy and Procedures.

This consent is effective for twelve (12 months) or until treatment is terminated.

_____

Client Name (Please Print)

_____ _____

Client/Legal Representative signature **Date**

_____ _____

Provider Representative signature **Date**

THE PSYCHOLOGY CLINIC, Inc.
TELEHEALTH CONSENT FORM

(Required in the Event Telehealth is Necessary)

Definition of Services:

I, _____, hereby consent to engage in telehealth with my treatment provider at The Psychology Clinic, Inc. Telehealth is a form of psychotherapy or psychiatric services via internet technology, which can include treatment, consultation, telephone conversations and/or psychoeducation using interactive audio, video or data communications. I also understand that telehealth involves the communication of my mental health information, both orally and/or visually.

Telehealth has the same purpose or intention as psychotherapy or psychiatric services that are conducted in person. However, due to the nature of the technology used, I understand that telehealth may be experienced differently than face-to-face treatment sessions.

Client Rights, Risks and Responsibilities:

1. I, the client, have the right to withhold or withdraw this consent at any time without this affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my mental health/medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my treatment is confidential, except as when mandated by law or allowed through my permission.
3. I understand that there are risks and consequences of participating in telehealth despite best efforts to ensure the use of high encryption and secure technology. These risks include, but are not limited to, the possibility that telehealth services could be disrupted or distorted by unforeseen technical problems and/or the transmission of my information could be interrupted or accessed by an unauthorized person.
4. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in telehealth. I am responsible for (1) providing my own necessary equipment for my telehealth sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions. It is the responsibility of my treatment provider to do the same on their end.

_____

I have read, understand and agree to the information provided above regarding telehealth:

_____ _____

Client/Legal Representative signature **Date**

_____ _____

Provider Representative signature **Date**

THE PSYCHOLOGY CLINIC, Inc.

CLIENT EMAIL AND/OR TEXTING INFORMED CONSENT

Risks of Using Email and/or Texting:

The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

1. Email and texts can be circulated, forwarded, stored electronically and on paper and broadcast to unintended recipients.
2. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
3. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
4. Employers and on-line services have the right to inspect emails sent through their company systems.
5. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
6. Emails and texts can be used as evidence in court.
7. Emails and texts may not be secure and therefore, it is possible that the confidentiality of such communications may be breached by a third party.

Conditions for the Use of Email and/or Texting:

Therapists cannot guarantee, but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapists are not liable for improper disclosure of confidential information that is not caused by the therapists' intentional misconduct.

Clients/parents/legal guardians must acknowledge and consent to the following conditions:

1. Email and texting are not appropriate for urgent or emergency situations. Providers cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
2. Email and texts should be concise. Clients/parents/legal guardians should call and/or schedule an appointment to discuss complex and/or sensitive situations.
3. Email will usually be printed and filed into the client's medical records. Texts may be printed and filed as well.
4. Providers will not forward client/parent/legal guardian identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
5. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
6. Providers are not liable for breaches of confidentiality caused by the client or any third party.
7. It is the responsibility of the client/parent/legal guardian to follow up and/or schedule appointments, if warranted.

Client Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me. I consent to the conditions and instructions outlined in this document. I also consent for use of my email for reminder messages about upcoming appointments.

_____

Client Name (Please Print)

_____

Client/Legal Representative Email Address

_____ _____

Client/Legal Representative signature **Date**

_____ _____

Provider Representative signature **Date**

THE PSYCHOLOGY CLINIC, Inc.
CLIENT BILL OF RIGHTS

Wisconsin State Statutes require that every clinic certified by the State of Wisconsin Department of Health Services to provide outpatient mental health treatment, alcohol and other drug abuse treatment and emergency services (such as The Psychology Clinic, Inc.) notify its clients of their rights that are guaranteed by state law (under Wisconsin Statute 51.6 (1), DHS 94 Wisconsin Administrative Code, Wisconsin Statute 51.30 and DHS 92 Wisconsin Administrative Code).

PERSONAL RIGHTS:

- You must be treated with dignity and respect, free of any verbal or physical abuse.
- You have the right to have staff make fair and reasonable decisions about your treatment and care.
- You cannot be treated differently because of your race, national origin, sex, age, religion, disability or sexual orientation.

TREATMENT AND RELATED RIGHTS:

- You must be provided prompt and adequate treatment.
- 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 and possible side effects of medications.
- No treatment or medication may be given to you without your 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 can consent to treatment and medications on your behalf.)
- You must not be given unnecessary or excessive medication.
- You must be informed of any costs of your care and treatment that you or your relatives may have to pay.

RECORD PRIVACY AND ACCESS LAWS:

- Staff must keep your treatment information private (confidential).
- Staff cannot release your records without your consent, unless the law specifically allows them to do so.
- You can ask to see your records. Staff must show you any records about your physical health or medications. Staff may limit how much you can see of the rest of your records while you are receiving services. They have to provide you reasons for any such limits. You can challenge these reasons in the grievance process. After discharge, you can see your entire record if you ask to do so.
- If you believe something in your records is wrong, you can challenge its accuracy. If staff will not change the part of your record you have challenged, you can put your version in your record.

RIGHT OF ACCESS TO COURTS:

- You may sue someone for damages or other court relief if they violate any of your rights.

GRIEVANCE RESOLUTION PROCESS:

- If you feel your rights have been violated, you may file a grievance.
- You cannot be threatened or penalized in any way for filing a grievance.
- The service provider or facility must inform you of your rights and how to use the grievance process.
- You may, at the end of the grievance process, or any time during it, choose to take the matter to court.

Contact your Client Rights Specialist, whose name is shown below, to file a grievance or to learn more about the specific grievance process used by the agency from which you are receiving services.

Your Client Rights Specialist is:

Terry Murphy at (608) 234-3421

Any person who receives services at The Psychology Clinic, Inc. is asked to review and sign a copy of this client rights and grievance procedure information sheet. You may retain a copy of this form. Your signature indicates that you have been provided this information and that you have reviewed this document.

_____ _____

Client/Legal Representative signature **Date**

_____ _____

Provider Representative signature **Date**