Appointment Reminder Consent

The purpose of this consent is to leave messages with family members or on voicemail regarding a scheduled appointment, or to notify the client to please call the office to discuss an issue or concern. At no point in time will we ever discuss details of your treatment (unless otherwise discussed between you and your provider). This service is offered as a courtesy, and we fully intend to respect your rights in regard to privacy.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance to your prior consent.

*In order to provide effective communication, please be sure that your voicemail is set up and able to receive message in the event of inclement weather or emergency cancellations.

Communications via Voicemail: Yes ☐ No ☐

Client Name: _____

Client Signature (18 and older) : _____ Date: _____

Parent/Guardian Signature (Under 18) : _____ Date: _____

Text Message Appointment Reminders

Lake Geneva Wellness Clinic, LLC offers automated appointment reminders via text as a courtesy to our clients. Please indicate your preferences below.

Please note that this is a courtesy, and you will still be held responsible missed appointments even if you do not receive a reminder.

Automated appointment reminders via text message: Yes ☐ No ☐

Primary phone number to receive automated reminders: _____

Name and relation to client (If not client): _____

Additional phone number to receive reminders via text message (if applicable): _____

Name and relation to client (If not client): _____

Additional communication via text message: Yes ☐ No ☐

Email Communication

Allow communication via email: Yes ☐ No ☐

If you opt out of emails, please note this will affect your notifications that contain links for telehealth and completing paperwork online.

LAKE GENEVA WELLNESS CLINIC, LLC
Ph: 262-248-7942 Fax: 262-248-1202

RECEIPT OF HIPAA PRIVACY PRACTICES FORM

I, _____ _____, hereby acknowledge that
(First Name) (Last Name)
I have been informed of the PHI (Protected Health Information) and HIPAA (Health Information Portability and Accountability) requirements of Lake Geneva Wellness Clinic.

**This information is included and is available at our office and on our website (https://www.lakegenevawellnessclinic.com/forms).*

Client Signature: _____ Date: _____
(Or Parent/Guardian)

Financial Policy

☐ **Lake Geneva Wellness Clinic, LLC**
750 Veterans Pkwy Suite 100
Lake Geneva, WI 53147
262-248-7942

Individual, Couple, or Family Psychotherapy		
If provided by Social Worker (LCSW)	$200 Initial Evaluation	$160/session
If provided by Counselor (LPC)	$200 Initial Evaluation	$160/session
If provided by Counselor in Training or APSW		$100/session
If provided by Intern		No Charge
AODA Assessment	$300	
Missed appointments	$100	
Check return fee	$40/per check	

If we do not take your insurance private pay may be an option at a possible reduced rate.

PLEASE READ AND INITIAL:

***MISSED APPOINTMENTS:** Therapy is most effective when appointments are made and kept. However, if you do need to cancel an appointment please do so at least 48 hours in advance. Please call the clinic and leave a message on the confidential voicemail if we are closed. You will be charged for appointments canceled less than 48 hours in advance.
**** If you miss (2) Appointments without canceling per policy above, you may be discharged.
*****We understand emergencies and unexpected circumstances come up that prevent you from canceling within 48 hours. However, if you have multiple late cancellations you may be discharged. **Initial_____**

In order to prevent insurance fraud, we will only be able to use insurance from the date the client authorizes Lake Geneva Wellness Clinic, LLC to use the insurance and forward. We are unable to backdate insurance claims. You will be responsible for any charges not covered. **Initial_____**

Copays are due at the time of service. **Initial_____**

THIRD PARTY BILLING: If you make an appointment for yourself, your child, or stepchild, payment is your responsibility. The Lake Geneva Wellness Clinic, LLC will send a duplicate statement to a third party; however, the party initiating treatment will be responsible for payment to the Lake Geneva Wellness Clinic, LLC. (We will, of course, bill insurance companies directly where adequate coverage is available.) **Initial_____**

MARITAL COUNSELING-RESPONSIBILITY OF PAYMENT: Each spouse is jointly and severally responsible for the entire amount of the charges incurred by either or both spouses. **Initial_____**

PRIVATE PAY CLIENTS: If you are a private pay client, there is a minimum of ½ of the agreed reduced fee amount due at the time of service. **Initial_____**

TERMINATION FOR FINANCIAL REASONS: In the event that you have a balance due of $300.00 or higher, you will be required to make a payment arrangement with the office manager before you will be able to schedule sessions in the future. If you do not make a payment as scheduled you will be discharged and referred elsewhere. **Initial_____**

****ADDITIONAL PRORATED BILLING: may be made for phone calls, preparation of reports, test scoring and review, handout materials, tapes, consultation, court appearances, writing letters on client's behalf, etc.** **Initial_____**

Medicare Part B will NOT pay for services rendered to any person who is part of ANY penal regulation or incarceration.

WAIVER OF RIGHT TO CONFIDENTIALITY IN CASE OF COLLECTION PROCEDURE: Lake Geneva Wellness Clinic, LLC reserves the right to release client information to our attorney or collection agency if necessary to collect past-due charges after client has been notified of impending collection procedures.

PLEASE FEEL FREE TO REQUEST CLARIFICATION OR FURTHER INFORMATION REGARDING OUR PAYMENT POLICY PRIOR TO YOUR FIRST VISIT.

_____

I understand and will abide by the Lake Geneva Wellness Clinic, LLC's policies regarding fees and services.
I realize that the Clinic programs are geared toward promotion of self-responsibility as much as possible for each client. In this regard, I am prepared to expend as much effort as necessary to improve upon the quality of my life and lifestyle.

Signature_____ Date_____

LAKE GENEVA WELLNESS CLINIC, LLC
Ph: 262-248-7942 Fax: 262-248-1202

CLIENT RIGHTS AND INFORMED CONSENT

Client name: _____

Patient Rights
When you receive any type of therapy service, you have the following rights under Wisconsin Statute sec 51.61 (1) and HFS 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 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 may be given to you without your written, informed consent, unless it is needed in any 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 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.

I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from the Lake Geneva Wellness Clinic. 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 (when applicable)
e. Probable consequences of not receiving treatment

The evaluation or treatment will be conducted by a psychotherapist, licensed clinical social worker, licensed professional counselor, 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

Client (or parent/guardian) _____ Date _____

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 to prevent harm, or to protect the client or minor.
- 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., or HFS 92, Wisconsin Administrative Code, is available upon request.

Information from my evaluation and/or treatment is contained in a confidential record at the Lake Geneva Wellness Clinic, and I consent to disclosure for use by the Lake Geneva Wellness Clinic 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.

Client (or parent/guardian) _____ Date _____

Patient Responsibilities

- Every patient is responsible for following all clinic rules and regulations affecting patient care and conduct.
- Every patient is responsible for providing a complete and accurate medical history and cooperating with the treatment plan and procedures prescribed for his/her care.
- Every patient is responsible for abstaining from unauthorized drugs or intoxicating beverages during the period of outpatient treatment.
- Every patient is responsible for making it known whether he/she clearly comprehends a contemplated course of action and the things he/she is expected to do.
- Every patient is responsible for being considerate of the rights of other patients and clinic personnel and property.
- Every patient is responsible for providing the clinic with accurate and timely information concerning his/her sources of payment and ability to meet financial obligations.
- Every patient is expected to be responsible and call in forty-eight (48) hours before they cancel appointments with their therapist. Failure to do so may result in a charge for the session missed. If a patient decides to terminate treatment, it is expected and hoped that the patient will meet with his/her therapist and discuss aftercare plans so that the termination exit will go smoothly
- Patient is responsible for using their insurance benefits appropriately. The clinic may be required to notify the insurance company if fraud is suspected.

Grievance Procedure and 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. Note: There are additional rights within sec. 51.61(1) and HFS 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 HFS 94, Wisconsin Administrative Code is available upon request.

****Right to Withdraw Consent**

- You have the right to withdraw your consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

****Expiration of Consent**

- **This consent to treat will expire in 12 months from the date of signature, unless otherwise specified.**

I have read the above information and have been notified of my rights and the grievance procedure available to me. I have had an opportunity to ask questions about this information, and I consent to the evaluation and 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 about the above information at any time.

Client (or parent/guardian) _____ Date _____

Communication through social media, email, and texting

If you communicate confidential or private information via email or text messaging Lake Geneva Wellness Clinic and its providers and staff will assume you have made an informed decision, and will view it as your agreement to take the risk that such communication may be compromised. It is understood that email and text messaging is not confidential and are not encrypted. Emailing and text messaging can be easily compromised and monitored.

Lake Geneva Wellness Clinic and its providers and staff will not accept friend requests from current or former clients on social networking sites due to the fact that these sites can compromise clients confidentiality and privacy. For the same reason we request that you do not communicate with us via any social networking sites. It is the preference of Lake Geneva Wellness Clinic to only respond to email or text messaging by scheduling an appointment in order to address your concerns privately and confidentially.

Therefore, I understand that if I use email or text messaging as a method of communication with my provider at Lake Geneva Wellness Clinic that my provider at Lake Geneva Wellness Clinic is not liable for any HIPAA violations or confidential information that may be exposed. I also understand that emails and important text messages will become a part of my chart.

Please do not use email or text messaging for emergencies- Call 911 or the Suicide & Crisis Lifeline at 988 or chat 988lifeline.org

You MAY call or text 262-374-3745 to get in contact with your provider (outside of normal business hours) in the event of a crisis. Typically the provider will reach out to you within 24 hours. Please call the office during normal business hours at 262-248-7942.

Client (or parent/guardian) _____ Date _____

Lake Geneva Wellness Clinic, LLC 750 Veterans Parkway, Suite 100, Lake Geneva, WI 53147 ph. 262-248-7942

Telehealth Informed Consent

I understand that telehealth is being utilized by Lake Geneva Wellness Clinic, LLC as an option to be seen when in person visits are not convenient or possible due to weather, health issues, transportation issues or scheduling issues. I also understand that Lake Geneva Wellness Clinic, LLC also offers in person outpatient mental health counseling, and that I have the option to meet in person with my provider.

I hereby consent to engage in telemental health (internet based therapy) with Lake Geneva Wellness Clinic LLC, as a venue for my psychotherapy treatment. I understand that telemental health includes the practice of health care delivery, including diagnosis, consultation, treatment, and education using interactive audio, video, and/or data communication.

All protections and limitations of HIPAA are the same for online therapy as they are in person, as outlined in the Privacy Policies you have already received from our clinic.

I understand that I will need to login to my client portal on Therapy Notes to use this telehealth platform. In order for the telehealth platform to work well, be sure that you're using the latest version of Google Chrome, Microsoft Edge, Apple Safari, Edge or Mozilla Firefox. A link will be sent via email for you to set up your client portal. Due to security reasons, you cannot reset your password, if you forget it. If you do forget your password please contact the office and we can send you another link to reset your password. To get the best results our platform works best on a computer. You can use your smartphone if it uses Safari. Therapy notes may not work on other browsers.

I understand that using the phone or telehealth platforms from home may involve the risks of others hearing my conversation that are in my home, that technology is not 100% safe and that my information could get breached.

It is important to maintain a setting that is as similar to being in an office together as possible. Maintaining the structure of the setting is critical. In order to have effective online therapy sessions, the following guidelines must be followed:

- Your device must be placed on a steady surface throughout sessions, and not held in your hand if it can be avoided. If it must be in your hand, please hold it as steady as possible. You should also be in a set location and not moving about.

- Make sure that you are in a private location where your sessions cannot be overheard by others. Make sure to adjust the volume on your device to ensure your privacy. You are required to inform me if there is anyone in the room with you, or who you believe may overhear the session.

- Try to have proper lighting so that I can best communicate with you.

- You must be appropriately attired each session, including being fully dressed and sitting in an appropriate setting for our session.

- Minimize background noise. Turn off televisions, music or other sounds. Please close the door to the room you are in.

- Minimize distractions. You should not be playing games on a device, be on social media, or working on other things while in therapy. Make sure that pets, children, household members and roommates will not be distractions from treatment.

- You may not invite others into session time without discussing this with me first.

You must login to your portal to start your telehealth session. If you are unable to connect please call the office 262-248-7942 or email your provider. If the connection is broken for any reason, your provider will try to reestablish a connection via telehealth. If they are unable to do that they will call you to remedy the situation. You will get a call from a restricted number, please switch your phone settings to accept restricted numbers before your session, in case your provider needs to reach you by phone. The session will continue over the phone until the telehealth platform can be resumed or your session time ends.

I understand that I have the following rights with respect to telemental health:

- I have the right to withdraw consent at any time without affecting my right to future care or treatment.

- The laws that protect the confidentiality of my medical information also apply to telemental health. As such, I understand that the information disclosed by me during the course of my therapy 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; expressing threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (See also Privacy Policies)

- I understand that there are risks and consequences from telemental health. These may include, but are not limited to, despite reasonable efforts on the part of my psychotherapist, that: the transmission of services could be disrupted or distorted by technical failures; misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner; and/or possible confidentiality breaches if someone should walk into the client's room while in a psychotherapy session.

- In addition, I understand that telemental health based services and care may not yield the same results for me as face-to-face service. If I notice this, I understand I may request in person sessions and decline telehealth sessions at any time.

- I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service (e.g. face-to face service), I will be referred to a psychotherapist in my area who can provide such service.

- I understand that I may benefit from telemental health, but results cannot be guaranteed or assured. The benefits of telemental health may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

If there is an emergency during my session, for example, I fall or become ill, my provider has my permission to contact_____ my _____ at _____.

If possible I would prefer to go to this hospital _____ and my primary physician is _____ at_____.

In emergencies, call 911 or go to your local emergency room.

You may contact the suicide& crisis hotline by calling or texting 988 or chat at 988lifeline.org

Your therapist can be contacted during business hours and will return calls within one business day, or as soon as they are able.
Your therapist is located at: 750 Veterans Parkway Suite 100, Lake Geneva, WI 53147.

I, _____, understand and have read the policy on Telehealth for Lake Geneva Wellness Clinic, LLC.

_____
Client Signature Date

_____
Guardian Signature (for minor clients) Date