Marriage & Family Solutions, LLC 7818 Big Sky Drive #101 Madison, WI 53719

Informed Consent for Behavioral Health Services as provided by Marriage & Family Solutions, LLC (MFS)

It has been determined that you are appropriate to receive outpatient services from MFS. The clinic wants you to be aware of your rights as a client and requests your informed consent to treat you. Your signature below indicates that you have been explained treatment alternatives, you wish to receive services from MFS, that you have received, reviewed, can request a copy of any policy at any time, understand and you are in agreement with the following:

1. The Client Rights Statement
2. Treatment Information – risks, benefits, and
3. Fee schedule and payment arrangements
4. Clinic Policies and Emergency Access Information
5. The Grievance Procedure

Client Rights

You have the right to…

- ask questions about any procedures used during therapy; if you wish, your therapist will explain their approach and methods to you.
- decide not to receive therapeutic assistance; if you wish, you will be provided with the names of other qualified professionals whose services you might prefer at a cost equal to or less than my own usual customary fee.
- to end therapy at any time without any moral, legal, or financial obligations other than those already accrued. I ask that you contact me by phone if you make such a decision without consulting with me.
- confidentiality (See the Limits of Confidentiality section below).
- request any part of your record in the files to be released to any person or agency you designate. Your therapist will tell you at the time whether or not I think releasing the information in question to that person or agency might be harmful in any way to you.

Limits of Confidentiality

Within limits of the law, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your written permission. Additionally, when more than one family member is being seen in therapy, the therapist views the family as a whole as the client. Therefore, releases of information for family sessions require written approval of every consenting member of the family who was present at any time during the treatment.

You should also know that there are certain situations in which I am required by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, I am not required to inform you of my actions in this regard. These situations are as follows: (a) if you threaten grave or bodily harm or death to another person, I am required by law to call the authorities; (b) if a court of law issues legitimate court order (signed by a judge), I am required by law to provide the information specifically described in that order; (c) if you reveal information relative to child abuse, child neglect, or elder abuse, I am required by law to report this to the appropriate authority; (d) if you are in therapy by order of a court of law, the results of the treatment ordered must be revealed to the court; and (e) if you are seeking payment through an insurance company, I will be required to reveal confidential information to them (each insurer is different).

Treatment Information

Your therapist will work with you on developing a specific treatment plan that is regularly reviewed with you which includes; presenting problem(s), measurable treatment goals, treatment approaches, and an estimated length of treatment that will be updated as treatment progresses.

Benefits and Risks. Therapy will seek to meet goals established by all persons involved, usually revolving around a specific presenting problem. A major benefit that may be gained from participating in therapy includes a better ability to handle or cope with marital, family, and other interpersonal relationships. Another possible benefit may be a great understanding of family and personal goals and values; that may lead to a greater maturity and happiness as individual and increased relational harmony. Other benefits relate to the probable outcomes resulting from resolving specific concerns brought to therapy.

In working to achieve these potential benefits; however, therapy will require that firm efforts be made to change and may involve the experiencing of significant discomfort. Therapeutically resolving unpleasant events and relationship patterns can arouse intense feelings. Seeking to resolve problems can similarly lead to discomfort as well as relationship changes that may not be originally intended.

You have the right to know about the possible harmful results of therapy. The only clear harm I have witnessed has resulted from clients' using medical insurance for psychotherapy. Harmful events included: denial of insurability when applying for medical and disability insurance due to DSM-V (or previous editions) diagnosis (mental illness diagnosis, which are usually required for reimbursements under medical insurance); company (mis)control of information when claims are processed; loss of confidentiality due to the large number of persons handling claims; loss of employment, and repercussions of diagnosis in situations which require truthfulness about "mental illness", including driver's licenses applications, concealed weapon permits, and job applications.

Fee Schedule and Payment Arrangements

By signing this form you are agreeing to enter into therapy with _____________________________ and to pay $135.00 for each session, with a delayed payment. If the criteria is met, you may be eligible for the immediate pay discount of (circle) $110, $75, or $40 for sessions. If you need records released or letters written there may be a fee of $26 and a minimum of 5 business days' notice for completion. Court attendance or phone conferences may be charged the same amount as a therapy appointment per hour. Travel charges will vary but agreed upon prior to the appearance.

Payment is due at the end of each session, and no balance will be carried. Co-payment is due at the end of each session. You are responsible for cooperating with your insurance company to support prompt payment.

If your insurance company does not pay for treatment that you will be responsible for payment in full.

Your therapist has the right to seek legal recourse to recoup any unpaid balance. In pursuing these measures, the therapist will only disclose biographical information and the amount owed, in order to ensure confidentiality.

You can leave therapy at any time and have no moral, legal, or financial obligation to complete the maximum number of sessions listed in this contract.

A 24 hour notice is required for cancellation of a scheduled session. If I do not meet this requirement, I agree to pay the full session fee. I understand this will be my responsibility, not that of the third party payer. I will be allowed one late cancellation (less than 24 hours' notice) or one missed appointment before having an option to be transferred a maximum of one time to another clinician or to another clinic.

If you arrive 15 minutes or more after your appointment time, your therapist may not be able to see you. Showing up 15 minutes or more late applies to the same policy as late cancellations and missed appointments.

Clinic Policies and Emergency Access Information

If our cancellation policy (listed above) is violated; if there is misconduct in the clinic; if this contract is violated; or if you are in need of a higher level of care than we can offer you, you will be discharged from our clinic. It is our policy that we will offer referrals for any voluntary or involuntary discharge from the clinic.

Emergency Access Information. When the clinic is closed or it is after-hours, MFS has an emergency crisis line. This line is NOT to be used for talk therapy, it is to be used for emergencies only. Our after-hours emergency only crisis phone number is 608-852-0698.

Grievance Procedure

If you have any complaints regarding your therapy or our clinic, we first recommend you talking to your therapist regarding the matter. If this is not something that you feel comfortable doing or feel it will not resolve your issues, you may contact our clinic director, Crystal D'Orazio, LMFT, CSAC by calling our office line and requesting to speak with her.

Your signature on this form indicates that you have had time to study the information and to ask any questions that you have concerning the proposed treatment/services and that you understand and agree to all this form states. If requested, you may have a copy of your client rights, as well as duplicate copies of both documents for your own use. This form is effective for 12 months after the date it was signed.

Client(s):______________________________________ Date:_________________

______________________________________ _________________

Therapist:______________________________________ Date:___________________