helping people with developmental disabilities participate in our community...

Community Support Network, Inc

Collaborations

1191 North Sherman Avenue, Madison, Wisconsin 53704
Web: www.VisitCSN.org
Phone: 608-421-3239 Fax: 608-270-2238

...bringing our community together

This box is for office use		
PSS Name:	PSS Number:	Date:
Clinician Name and Credential:		Clinician Title:

Informed Consent for Treatment - Updated July 2014

Therapeutic Services

I understand that I have the right to participate in the development and ongoing review of my treatment plans to meet my individual needs, which reflect my strengths and respects my cultural values, beliefs and traditions.

I understand the following points of information about the therapy process and treatment:

- The purpose of therapy is to help alleviate the problems and symptoms that I present.
- Therapy is conducted in sessions between my therapist and me talking about the problems presented.
- If there are any expected side effects from therapy, they will be discussed with me.
- My therapist will suggest alternative treatment modes and assist in referrals when appropriate and necessary.
- The possible consequences of not receiving therapy or of ending therapy will be discussed.

PSS Fees

Fees will be charged as follows:

- Diagnostic Evaluations/Assessments/Intakes: $140 up to 90 minutes in length
- Individual sessions and Collaborative Participant Exchanges: $140 per 60 minute session ($70 per 30 minute session, $105 per 45 minute session)
- Explanations and/or preparations of treatment progress and/or advising on how to assist the PSS: $140 per hour (billed in quarter hour increments)
- Groups sessions $20.00 per 75 minute session, per participant

A 30 day notice will be provided (verbally and in writing) any time there is a fee adjustment.

Confidentiality

I understand that Collaborations takes the confidentiality of my information seriously and will make reasonable efforts to protect the confidentiality of information about my case. Confidentiality about my care is protected by CSN's policies and by state and federal regulations. It has been explained to me that legal and ethical requirements specify certain conditions in which it will be necessary for confidential information about my care to be discussed with persons outside the agency. These conditions include the following:

1. Situations that involve danger to myself or others.
2. Neglect or abuse of children, elderly, or disabled persons.
3. Court ordered release of my records.
4. In the case of minors under the age of 14, parents or guardians have the right to information about my case. (Minors can choose to be present.)
5. In the case of minors between the ages of 14 and 18, parents or guardians have the right to general information about my case. (Minor can choose to be present.)
6. As part of my therapist's supervision and case review process, my case will be discussed with my therapist's supervisors and, on occasion, a supervisor may be present in the therapy room during treatment.

How to Address Concerns
If I feel the need to address concerns, I will do so directly with my therapist. My therapist has also reviewed the Grievance Procedure (both formal and informal) with me.

PSS Responsibilities
In order for my work in therapy to be successful I understand that it is essential that I attend sessions and make a sincere effort to work on the issues that my therapist and I are addressing. If for some reason I cannot attend a scheduled session, I will make every attempt to call at least 24 hours before the session to cancel.

Contact Information
My therapist can be contacted for making and cancelling appointments by calling 608-421-3239. I understand that I will need to leave a message on this phone number and my therapist will return my call as soon as possible. If I experience an emergency which requires prompt medical or police attention, I will call 911.

PSS Rights
When I receive services for mental health as an outpatient, I have the following rights:
- To be provided specific, complete and accurate information about treatment.
- To be free from having unreasonable arbitrary decisions made about me.
- To receive prompt and adequate treatment.
- To refuse any treatment, including medications.
- To have a safe treatment setting, free from sexual, physical and emotional abuse.
- Refuse to answer any questions or give any information I choose not give/answer.
- Refuse audio or video recording of sessions.

Email Communication
Collaborations maintains policies regarding email use to protect personal health information and confidentiality. However, the email system used by Collaborations is not encrypted. Collaborations workforce members do use email to communicate with those identified in signed Releases of Information, as well as with appropriate members of the Collaborations and Community Support Network, Inc workforce.

PSS(s) Signature(s)
I have read and understand this document and have asked any questions I have regarding the above information. I agree to participate in treatment under the conditions described. By signing this form I:
1. Give consent for services.
2. Acknowledge that I have been informed about my rights and responsibilities.
3. Understand that this consent is valid for one year from the date I sign and that I may withdraw consent, in writing, at any time.
4. I've received a copy of
    a) Therapy Privacy Practices Notice (including "Your Rights" section)
    b) Grievance Procedure and Grievance Form
    c) Important Policies to Be Aware Of (including information about Releases of Information, Emergency Services, Composite Files, Termination Phase and Involuntary Discharge)
    d) Access to Records
    e) Financial Policies

Person Seeking Support (PSS) Signature ______________________________ Date______________

PSS Signature/Guardian _________________________________ Date ______________

Therapist Signature _________________________________ Date ______________

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Clinician Name and Credential: Clinician Title:

Financial Policies - Updated July 2014

The Person Responsible for Payment (PRP) is required to sign the Payment Contract for Services form, which explains the fees and collection policies of Collaborations. Your insurance policy, if any, is a contract between you and the insurance company. Collaborations is not part of the contract with you and your insurance company.

As a service to you, Collaborations will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amounts covered and is not responsible for the collection of such payments. In some cases insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the PRP is responsible for payment of these services. We charge standard rates for the area. PRPs are responsible for payments regardless of any insurance company's determination of standard rates. The PRP will be financially responsible for payment of such services. The PRP is responsible for paying fees not paid by insurance companies or third-party payers after 30 days from the date of notice.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere, this amount will be collected by Collaborations until the deductible payment is verified to Collaborations by the insurance or third-party payer.

All insurance benefits will be assigned to Collaborations by the insurance company or third-party payer unless the PRP pays the entire balance each session.

If the PSS does not have insurance, the PSS will pay the standard fees. Fees will be charged as follows:

- Diagnostic Evaluations/Assessments/Intakes: $140 up to 90 minutes in length
- Individual therapy sessions, Couples, Family and/or Team therapy and Collaborative Participant Exchanges: $140 per 60 minute session ($70 per 30 minute session, $105 per 45 minute session)
- Explanations and/or preparations of treatment progress and/or advising on how to assist the PSS: $140 per hour (billed in quarter hour increments)
- Groups sessions $20.00 per 75 minute session, per participant

A 30 day notice will be provided (verbally and in writing) any time there is a fee adjustment.

The adult accompanying a minor (or guardian of the minor) and/or responsible team members of a PSS with developmental delays who cannot handle money is responsible for payments for the child/adult PSS with developmental delays at the time of service. Unaccompanied minors/adult PSS with developmental delays will be denied services unless charges have been preauthorized to an approved payment plan or payment at the time of service.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged half the standard rate for each session, based on the length and type of the appointment. Insurance cannot be billed for missed appointments or cancellations.

Payment methods include check or cash. Collaborations does not give out change.

Questions regarding the financial policies can be answered by the Collaborations Director of Therapeutic Services.

I (we) have read, understand and agree with the provisions of the Financial Policies.

PRP Signature: ______________________________ Date: ________________